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THE UNIVERSITY OF ALBERTA

ADOLESCENT HEALTH: AN EMIC PERSPECTIVE

by

©

LORRAINE ALINE TELFORD

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

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THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the FACULTY OF GRADUATE STUDIES AND RESEARCH, for acceptance, a thesis entitled ADOLESCENT HEALTH: AN EMIC PERSPECTIVE submitted by LORRAINE ALINE TELFORD in partial fulfilment of the requirements for the degree of MASTER OF NURSING.

Janice M Morse

Supervisor

Louise Payne

J Mitchell

Date September 18, 1987

To *Randall David Telford,*

one who truly demonstrates love and commitment.

Abstract

The purpose of this study was to discover and describe an adolescent view of health. Health professionals who work with this age group require an understanding of this emic perspective so that health planning can be congruent with the individual's or groups' perspectives. Nine sixteen and seventeen-year-old adolescents were selected from two subcultural groups, (academic and athletic), as informants for this study.

Data were collected and analyzed according to Spradley's *developmental research sequence method*. This method involves discovering the *structure* and *meaning* of a concept through the development of taxonomies and cultural themes based on ethnographic interview data and field notes. Using card sorts and Cantril's Self-Anchoring Ladder, two taxonomies were developed from the data in the interviews: the *Taxonomy of Health Characteristics* and the *Taxonomy of Strategies for Health.* Health was conceptualized as a process involving having the will to live, taking care of yourself and *goaltending* (choosing, working toward, and achieving goals).

Several cultural themes were identified, however, many of them could be reflective of the nature of the high-achievement oriented subgroups. In general, the data in this study are consistent with the findings in other similar qualitative studies of health. Data in this study are more rich and grounded in the views of the informants than in previous studies, as they were *inductively* developed, and the data are relatively similar, (although with different emphases), to other studies examining individuals' views of health. Further investigation is required to understand the degree to which the perspectives identified in this study are held by other groups in the adolescent culture. The ultimate aim is for health professionals to have a more thorough understanding of how adolescents perceive health in order to more effectively and efficiently promote the health of this population.

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I. INTRODUCTION

Understanding lay perceptions of health and the meaning of health are required for the art and science of nursing. Any health promotion strategy must incorporate the cultural milieu, because if services and programs are based on incongruent, or narrowly-conceived health goals, the efforts of those involved may be wasted. Nurses are often involved in health promotion activities with people in many age groups, with different cultural backgrounds, and in different settings.

Adolescents currently receive little formal or informal assistance to optimize their health (Feldman, Hodgson, Corber, & Quinn, 1986; Johnson-Saylor, 1980). At best, program planning is inconsistent and sometimes unsupported by administration in health units and schools, especially in secondary schools (C. Cameron, personal communication, June 17, 1986; Simmons, 1981; Stark & Siddons, 1983; E. Stewart, personal communication, June 10, 1986). The emphasis of the health care system is on intervening when problems arise; primary prevention and health promotion are of secondary importance.

A key word in providing services for adolescents is "appropriateness." Currently, professionals have insufficient information to determine if their teaching efforts are appropriate for this age group. Hypotheses and tool refinements required to measure program effectiveness need to be developed based on culturally relevant, qualitative data which are representative of the respective age group. Despite the need to have an understanding of the client's perspective of health, there is a lack of information describing lay persons' perspectives of health (Morse, 1987). In particular, an understanding of the *adolescent view* of health is not understood (Blum, 1982). Nurses and others have had to rely on conjecture and assumptions about adolescents' emic perspective of health and illness. This lack of knowledge about the adolescent perspective of health is thought by some scholars to have resulted in inappropriate and sometimes futile health promotion efforts for this population (Green, 1979). An understanding of adolescents' perceptions of health will help health care providers to approach adolescent health problems from the client's perspective and will increase the effectiveness of planned interventions. To this end, the purpose of this study was to discover and describe an adolescent view of health.

The following chapters explain a) the related literature for the study, b) the results of the study, and c) the discussion of the results, including the implications for nursing practice and the recommendations for nursing research. The definitions for the study precede these chapters.

Definitions for the Study

Disease: Acute and chronic conditions that are assessed and/or treated in the health care system.

Disease prevention: The activities within the programs in the health care system designed to prevent specific diseases.

Emic: Emic is derived from the word *phonemic* and its contrast, *phonetic* (Pike, 1954, cited in Leininger, 1985b). The emic approach attempts to describe the understanding of a setting, behavior, or in this case, a concept, from an informant's perspective. "The emic view is grounded in language and expressions..." (Leinginger, 1985b, p. 238). "Thus, cultural explanations and patterns are inductively 'discovered' within the cultural context rather than analysed from the researcher's perspective or a prior framework or theory" (Field & Morse, 1985, p. 137).

Health: A unique experience of well-being, as described by individuals.

Health promotion: The activities of health professionals designed to assist individuals or groups to maximize their well-being, including actions for generating, developing, maintaining, protecting, and restoring health (Simmons, 1986).

Illness: The experience of the absence of wellness, as described by individuals.

Meaning: The interpretation or significance attatched to a symbol or object (Funk & Wagnall, 1963).

Partial Ethnography: A partial description of selected aspects of a culture or subculture (Spradley, 1979). Similar to a mini-ethnography as described by Leininger (1985a).

Perception: The insight, knowledge and intuitive judgement from sensing and experiencing (Funk & Wagnall, 1963).

II. REVIEW OF THE LITERATURE

Scientific inquiry about adolescents' perceptions of health is limited. Only three studies using inductive approaches were identified (Brunswick, 1969; Hedin, Wolfe, & Arneson, 1977; Magilvy, McMahon, Bachman, Roark, & Evenson, 1987). Some researchers have attempted to measure the importance of health in relation to other perceived needs or concerns of adolescents (Bibby & Posterski, 1985; Levenson, Morrow, Johnson, & Pfefferbaum, 1983; Levenson, Morrow, & Pfefferbaum, 1984) and some researchers have reported findings about adolescents' perceived "health needs" (usually with illness-focused categories) (Feldman, Hodgson, Corber, & Quinn, 1986; Hedin, Wolfe, & Arneson, 1977; Turner, Smith, & Jacobsen, 1985). Consequently, this review will primarily focus on other literature that is related to lay and adolescent perceptions of health.

The purpose of this review is to examine theoretical and research documents that build the rationale and context for the need for and approaches of this study. The review will be organized around three areas: the need to understand adolescent health in nursing, understanding the adolescent culture, and theoretical, empirical, and lay understanding of the concept of health. An emphasis will be placed on current knowledge about perceptions of health.

Implications For Nursing

Presently, nurses are involved in developing, piloting (through consulting and teaching), and evaluating health education programs in Alberta schools. As health educators in schools, nurses are active in all grades, they act as resource persons and educators for parents, youth groups and other professionals (Mullen & Iverson, 1982; Simmons, 1980). Nursing knowledge of the perceptions of health of various age groups is critical for nurses in order to perform these roles effectively.

The medical care of adolescents primarily focuses on problems in the areas of nutrition, skin integrity, pregnancy, sexually transmitted and other communicable diseases, substance use, injuries, and behavioral and personality concerns (Blum, 1982; Cohen & Litt, 1974; Daniel, 1977; Friedman, 1981). Adolescents themselves emphasize concerns about interpersonal relationships, drug use (including alcohol), venereal disease, and pregnancy as *health problems* (Hedin, Wolfe, & Arneson, 1977). Both adolescents and health professionals emphasize taking action primarily when serious problems arise. The perception of what is a serious health problem may differ. Perhaps measuring or describing adolescent health by using primarily morbidity and mortality statistics is *invalid* because of the difference in perceptions and the focus on illness instead of health. (Feldman, Feldman, Milner, Caufield, & Sackett, 1982; Feldman, et al., 1986; Fuchs, 1976; Levenson, Morrow, & Pfefferbaum, 1984; Walter & Connelly, 1985).

Perry, Griffin, and Murray (1985) note that "... adolescents have recently become targeted for health promotion efforts to prevent chronic disease" (p. 379). Although they state that the evidence is "slim," they also state that the arguments about preventing chronic diseases through health promotion efforts in this age group are strong (Perry, Griffin, & Murray, 1985). However, in order to provide effective interventions and to identify appropriate health outcomes that address the current health concerns of adolescents, an emphasis on primary prevention is desirable. Information about the meaning of health and illness to adolescents must be the first step (Lewis & Lewis, 1984).

This study is expected to contribute to nursing in two areas: knowledge and practice. The descriptive data will add to the knowledge about the perceptions of health in this population. These data will provide a basis for further investigation with the ultimate aim to develop tools and methods for promoting adolescent health. The results will also contribute to further study about effective disease prevention. Nurses will, therefore, be able to more effectively fulfill their roles as consultants and educators in their practice.

Understanding Adolescence

The following review is organized around two purposes: to describe certain relevant characteristics of the adolescent who is sixteen or seventeen years-of-age, and to provide the rationale for the study of health perceptions of this age group.

Adolescents perceive the world differently from other age groups and can therefore be considered a subculture in our society. Generalized statements must be interpreted with caution, however, for diversity within cultures and subcultures exists, even within this age group (Spector, 1979; Spradley, 1979). Different perceptions, norms and expectations are likely to exist between the adolescent subculture and the nursing subculture (Spector, 1979), including the conceptualizations of health (Resnick, 1982; Tripp-Reimer, 1984). These differences can affect the helping relationship and can interfere with intervention outcomes (Morse, 1983).

Factors related to adolescence identified to be relevant to the research questions are: cognitive changes, values, and first experiences. The other characteristics that are presented are relevant because of their relationship to health and health promotion for adolescents. All of the characteristics are important to the rationale and design of this investigation.

The first characteristic is the developmental changes in cognition during adolescence. Mitchell (1986) describes older adolescents as becoming mentally and psychosocially similar to adults; however, regarding social roles "they remain essentially adolescents" (p. 157). Cognitive processes become propositional in adolescence (Elkind, 1984). Thoughts are more abstract, comprehensive, future-oriented, and less egocentric (Mitchell, 1986). There is a shift from defining oneself from others' perceptions to an identity in doing and making a difference (Mitchell, 1986). Thinking about values, meanings and the future is more common (Bibby & Posterski, 1985; Physicians for Social Responsibility, unpublished data; Konopka, 1973; Mitchell, 1976).

The second characteristic is the nature of the older adolescent's values. Kohlberg (Englund, 1980) and Inhelder and Piaget (1958) emphasize the individual nature of moral and cognitive development. The literature related to adolescence does not identify common adolescent values. Although values of adolescents can differ from adult values, adolescent values are usually closest to those values of the adults in their family (Bibby & Posterski, 1985; Offer, Ostrov, & Howard, 1981; Rice, 1981). However, the *peer group* becomes most influential for many adolescents during this time (Norman & Harris, 1981). Although some authors question whether adolescents often simply choose peers who have values similar to their own, the peer group is reported to influence some values (Bibby & Posterski, 1985; Lewis & Lewis, 1984). Because peer groups are important, they are sometimes involved in both data collection and as subjects in research (Hedin, Resnick, & Blum, 1980; Resnick, Blum, & Hector, 1980) or as leaders in health promotion programs (Alexander, 1983; Jordan & Kelfer, 1983; Myers & Whitlock, 1982) as strategies to improve participation in the research or acceptance of the program. Descriptions of programs such as these include praise of peer involvement, but no formal comparisons of using peers as opposed to adults are reported.

Another developmental characteristic relevant to this study is what Konopka (1973) calls *firsts*. Because adolescents have expanding cognitive and physical abilities, many adolescent experiences are new. Sexual "firsts" receive considerable attention in the health literature primarily because of the risk of sexually transmitted diseases and pregnancy (Health and Welfare Canada, 1983; Smith, Udry, & Morris, 1985). Substance abuse is also a health concern related to first experience. Based on a large follow-up study of student drug use, Newcombe, Maddahian and Bentler (1986) state that developmental factors *per se* are not causal in relation to morbidity in adolescence; they state that what *is* important to consider in analyzing adverse health behavior in this age group is how the adolescents are dealing with developmental changes.

Another characteristic that is important to consider in interaction with adolescents is that of *control*. Mitchell (1986) states that "adolescents have the capacity to make choices and they desire to exercise this capacity" (p. 167). McKnight (1985) speculates that, in general, poor health and health choices are associated with powerlessness. In Bibby and

Posterski's (1985) study of 3600 adolescents across Canada the issue of control emerged as a major theme in both quantitative and qualitative responses. Incorporating control and choice into adolescent health care is thought to be critical to program success (Green, 1979; Jordan & Kelfer, 1983; Levenson, et al., 1983; Parcel, Nader, & Meyer, 1977), and adolescents tend to agree (Hedin, Wolfe, & Arneson, 1977; Resnick, Blum, & Hedin, 1980).

It may be that these selected characteristics of adolescents partially explain the incongruence between health problems that are manifested in morbidity statistics for the older adolescent, and the concerns of adolescents reported in studies that approach adolescents about their health concerns (Feldman, et al, 1986; Hedin, Wolfe, & Arneson, 1977; Hodgson, Feldman, Corber, & Quinn, 1985; Parcel, Nader, & Meyer, 1977; Resnick, 1982; Turner, Smith, & Jacobsen, 1985). Adolescents perceive a gap between their needs and the services available (Feldman, et al., 1982, Green, 1979, and Hedin, Resnick, & Blum, 1980). Improvement in the quality of health is perceived as desireable by adolescents (Feldman, et al., 1986; Parcel, Nader, & Meyer, 1977) and health professionals (Daniel, 1977; Walter & Connelly, 1985). Further detail about adolescents' health needs and preferred models of health care, including the adolescents' health goals, is needed.

Hedin, Wolfe, and Arneson's (1977) analyses of open-ended interviews with 800 adolescents in Minnesota reveal that these adolescents were reluctant to seek help for many of their illness and health concerns. For example, most adolescents stated that problems would have to be "serious" to motivate them to seek assistance, and that "embarrassing" problems would inhibit them from consulting with others (Hedin, Wolfe, & Arneson, 1977). Although these authors have identified several factors to begin to examine, theories of health-seeking behavior in this age group lack discussion and substantiation by investigation.

Even though adolescents seem reluctant to seek medical and health care, there are data that support the idea that adolescents are concerned about their health (Bibby & Posterski, 1985; Physicians for Social Responsibility, unpublished data). In one local pilot study by the Physicians for Social Responsibility (unpublished data), 73 percent of 600 students, in grades seven to twelve, who completed a questionnaire, ranked good health as an important component of their future. Two qualitative investigations also report data that support this idea (Brunswick, 1969; Hedin, Resnick, & Blum, 1980). Nevertheless, information about what the individuals *mean* by "good health" is lacking.

Health

Understanding academic, professional and lay conceptualizations of health is central to nursing knowledge and vital for nursing practice (Allen, 1981; Egbert, 1980; Fawcett, 1984; Payne, 1983; Simmons, 1981). The broad, abstract concept of health has been discussed for centuries (Moravescik, 1976) and, the concept has received consideration by the health care system ever since there has been a significant decrease of major causes of early death (Breslow, 1972; Sebag, 1979). Health is seen by some scholars as an elusive concept; it is taken for granted and not thought about until one loses it (Cardus, 1973; Dubos, 1978; Frankl, 1967; Hoke, 1968; Kottow, 1980; Siegel, 1973). Moreover, the concept of health invariably involves consideration of the concept of disease or illness (Dunn, 1959; Fawcett, 1984; Payne, 1986).

In this review the investigator will demonstrate the importance of understanding the subjective perspective and social influences of health for promoting health in adolescents. The theoretical and empirical sections are designed to analyze the nature of the concept of health from their respective postures. In the third section labelled *Lay Perceptions*, the investigator will discuss the research about lay perceptions of health including adolescent perceptions.

Theoretical Perspectives of Health

Some authors have attempted comprehensive reviews of academic conceptualizations of health (Keller, 1981; Payne, 1983; Wolinsky, 1980), and these reviews are helpful in sorting through the copious volumes written about the concept. Smith (1981) has developed four models of health using the method of philosophic inquiry. She states that "[the four models] can...be viewed as forming a scale -- a progressive expansion of the ideal of health" (Smith, 1981, p. 47), beginning with the clinical model. Following the clinical model are role performance, adaptive, and eudaimonistic models, respectively. Futurists such as Capra (1982), Naisbitt (1984), Toffler (1980), and Robertson (1985) predict a shift in human awareness up the scale toward the eudaimonistic model, which is the most expansive. Each of Smith's models with descriptions and corresponding examples of authors are presented in Table 2.1.

Table 2.1: Smith's Four Models of Health and Corresponding Examples

MODEL	Corresponding Models
Eudaimonistic Model *exuberant well-being*	Dunn (1959) Maslow (Boddy, 1985) Sigerest (1941) WHO (1949)
Adaptive Model *flexible, maximized adaptation to and interaction with the environment*	Davies (1975) Dubos (1978) Mechanic (1980) Rogers (1970) Roy (1984)
Role Performance Model *maximum performance of social roles*	Fanshel (1972) Parsons (1972) Twaddle (1974)
Clinical Model *absence of signs and symptoms of disease*	Any medical definitions

The World Health Organization's (WHO)(1949) definition of health, first presented in 1947, slowly set in motion the polemic among scholars about health as an important "new" concept. Other theoretical concepts have emerged in an attempt to clarify health in relation to human experience. Dunn (1959a, 1959b) developed the concept of *wellness*. This concept qualifies those factors that are important in physical, mental and social well-being. Berne and Shantzis (1986) have incorporated the concept of wellness into health and lifestyle teachings. Bruhn, Cordova, Williams, and Fuentes (1977) developed wellness as a *process*, with accompanying developmental tasks. These scholars identify the nine tasks which are important for minimal wellness of adolescents:

1. learning economic responsibility,
2. learning social responsibility for self and others,
3. experiencing social, emotional, and ethical commitments to others,
4. accepting oneself and one's physical development,
5. reconciling discrepancies between personal health concepts and observed health behaviors of others,
6. learning to cope with life events and problems,
7. consideration of life goals and career plans and acquiring necessary skills to reach the goals,
8. learning the importance of time to self and the world, and
9. experiencing degrees of structure or flexibility in social institutions and interpersonal relationships (Bruhn, et al., 1977, p. 216).

Bruhn, et al (1977) uniquely present health as a different process for different age groups. They assume that health can be a personal achievement (Bruhn, et al., 1977). They present the concepts of health and wellness from a functional, descriptive perspective, which is similar to the adaptive and role performance models in Smith's (1981) framework, and their conceptualization of health is linked to western culture.

Brody and Sobel (1980) state that "what is judged as healthy or unhealthy varies from person to person and, even more dramatically, from culture to culture, because of highly individual requirements and relative social norms" (p. 169). In addition, perceptions of health are assumed to change with age as do perceptions of illness (Eiser, 1985; Natapoff, 1978; Robinson, 1986). Although Bruhn's, et al (1977) developmental perspective of wellness appears consistent with western culture, it is not based on analyses of actual processes identified from persons in the respective age groups. That is, the framework is deductively developed. Consequently, the specific wellness process and its tasks are open to question with respect to their validity. The framework is useful because it reflects cultural considerations.

As shown in Table 2.1, according to Smith (1981), adaptive and role performance models of health involve both individual and social perceptions in their respective definitions. For example, Parsons' (1972) sick role behavior is aligned with Smith's (1981) role performance framework, and Parson's perspective emphasizes subjective and context-specific interpretations. Lay perceptions of health tend to reflect the adaptive and role performance perspectives as well (Baumann, 1961; Hedin, Wolfe, & Arneson, 1977; Morse, 1983).

Keller (1981) performed analyses on the diverse concepts in 42 definitions of health. The overall theme of her review is that health is seen as a complex, variable, and *individualistic* phenomenon. In the conceptual literature, each of Smith's four models are discussed, but physical health definitions are most common (Keller, 1981). Most models of health incorporate at least the individual's perspective, with the exception of the clinical model that Smith (1981) identifies. This model bases health on another measure (such as that of a general practitioner) for "objective" evaluation. The clinical model removes the personal experience and subjective nature of health from the concept. The emic view of health is consistent with a more variable and broad perspective reflected in the three more expansive models (Illich, 1976; Naisbitt, 1984). The holistic perspective is closely linked to the open systems view and strongly emphasizes the importance of the individual's experience of health.

Empirical Perspectives of Health

Sebag (1979) states that Smith's four models are actively used in research. He states that the clinical model, which he refers to as the "curative system" is the predominant one. Perhaps empiricists avoid Smith's (1981) adaptive, role performance, and eudaimonistic frameworks because of the current orientation of "controlling" for variation, rather than an emphasis on observing and explaining the variation. The frustration and confusion in trying to facilitate and research eudaimonistic models of health may have induced efforts to objectify health; measurements commonly referred to as "health status measures" began to emerge. Authors, particularly in the medical literature, build a powerful argument to define health as a variable that is based in "empirical reality." The goal of the empiricists has been to answer the question of how to measure health and health outcomes.

Payne's (1984) review of health status measures concludes that there has been wide variation of frameworks upon which these measures are based. This variability adds to the difficulty of discovering how health could be validly measured. Antonovsky (1980) asserts that improper conceptualization of health interferes with our ability to attain or maintain health. Moreover, the use of morbidity and mortality statistics to describe health and plan health interventions has limitations (Antonovsky, 1980; Blum, 1982; Wolinsky, 1980). Planning based on these data may not address true health needs.

Recognizing its importance, some empiricists have incorporated individual perceptions in health status measures. Quantitative studies that measure the individual's health status perceptions often use a variation of the question "Would you say you are in: poor health, fair health, good health, or excellent health?" (Mechanic, 1972, 1980; Murray, Dunn, & Tarnopolsky, 1982; Tessler & Mechanic, 1978; Tornstam, 1975). Some quantitative researchers have ignored the subjective experience entirely from the assessment of health status (Davies, 1975). Fuchs noted in 1976 that the "...variation across individuals in their subjective evaluation of health shows the same relationship as does variation in age-adjusted mortality..." (p. 231). Thus, the subjective perception of health status is gaining support as a valid part component in health measures.

Based on the empirical studies that do consider individual perceptions, seven variables emerge which appear to be inherent in perceptions of health. These are: a) *illness* (physical or mental) (Baumann, 1961; Mechanic, 1972; Morse, 1983; Perrin & Shapiro, 1985; Tam, 1983; Tessler & Mechanic, 1978; Tornstam, 1975), b) *culture* (Brunswick, 1969; Keller, 1981; Mechanic, 1972), c) *age* (Fuchs, 1976; Murray, Dunn, & Tarnopolsky, 1982; Natapoff, 1978; Perrin & Shapiro, 1985; Robinson, 1986), d) *gender* (Murray, Dunn, & Tarnopolsky, 1982; Perrin & Shapiro, 1985), e) *family perceptions* (Duffy, 1986; Perrin & Shapiro, 1985; Richardson, 1986), f) *socioeconomic status* (Fuchs, 1976; Keller, 1981; Laffrey, 1985), and g) *education* (Baumann, 1961; Laffrey, 1985).

Those who are physically ill tend to perceive health differently than those who describe themselves as "well" (Morse, 1983). Those who report physical and mental wellness tend to view health as an encompassing positive experience with psychological dimensions (Brodie, 1974; Morse, 1983; Perrin & Shapiro, 1985). Also, those who are under mental strain tend to view themselves as less healthy physically (Mechanic, 1972; Tam, 1983; Tessler & Mechanic, 1978).

The cultural milieu is inherent in health perceptions, sometimes in subtle ways that are difficult to describe explicitly (Spector, 1979; Tripp-Reimer, 1984). This is true for the adolescent subculture (Brunswick, 1969). Family perceptions are closely related to the cultural variable, but since several studies have examined it directly (Duffy, 1986, for example) it has been identified separately. Adolescents claim their parents' values influence their own values (Bibby & Posterski, 1985), but how or to what degree the influence occurs in relation to health was not determined.

Age and gender are often addressed in discussions of health perceptions, however the exact nature of the way health is viewed in different age and gender combinations has yet to be fully examined (Hester, 1984). The adolescent age group is rarely the subject in discussions about age and gender and health perceptions (Hedin, Wolfe, & Arneson, 1977).

Socioeconomic and education factors are two variables which are also underexamined. For example, the question of whether the variable of education is similar to the socioeconomic status or cultural variable is not addressed in the literature.

Many, but not all, of the investigations that present these variables provide little information about the specific methods of analysis for each variable. The significance and relationship of the variables to health perceptions remains vague and loosely descriptive. It is important to examine each variable within its respective context in order to explain the potential inherent differences of health perceptions of individuals. Most of the authors that address these variables emphasize incorporating the subjective perceptions of health as an indicator of health status; some of the scholars argue for qualitative study to consider the importance of various indicators more carefully (Breslow, 1972; Davies, 1975; Fanshel, 1972; Fuchs, 1976; Kobassa, 1979; Murray, Dunn, & Tarnopolsky, 1982; Payne, 1984; Tornstam, 1975).

In conclusion, both the theoretical and empirical perspectives of health reveal much information about the phenomenon. Authors from both systems generally present arguments for quantitative *and* qualitative assessment of health and suggest incorporating self-perceptions of health in its measurement. The analysis of the ***meaning*** and ***experience*** of health to persons, in their perceived world, is underexamined. The following section is a review of the literature that relates to the meaning of health from the lay person's perspective, including the adolescent lay person.

Lay Perceptions of Health

In 1979, Idler argued that a "fundamentally new approach to the concepts of health and illness, as they are understood by... laity, is badly needed for future research...to remain relevant to social reality" (p. 723). The following studies used qualitative methodologies for determining perceptions of health, and were primarily comprised of descriptive data. This is in contrast with empirical studies which generally lack contextual description.

Lay persons are reported to describe health with a phrase like: "being able to do what you want to do," and the individuals imply that the absence of health is not as desirable as its presence (Baumann, 1961; Brunswick, 1969; Idler, 1979; Morse, 1983; Natapoff, 1978; Robinson, 1986). The researchers who extract qualitative data do not always describe the questions asked or their methods of analysis in study reports. Consequently, the procedures cannot be judged for adequacy and credibility. The authors explain health perceptions in various contexts: some describe perceived health states (Baumann, 1961); some describe the perceived criteria for health; and some describe health perceptions as interpretations and experience (Morse, 1983; Payne, 1985; Robinson, 1986). Pelkonen and Astelt-Kurki (1986) have proposed a qualitative analysis of health and will be analyzing and comparing lay persons' and health professionals' perspectives of health from written data, as part of a larger primary prevention study.

Notably, the literature addressing lay perceptions of health is more recent. The 1970s generally mark the period for a dearth of qualitative health studies. Prior to 1970, two studies were done involving the use of open-ended questions in order to describe perceptions of health. Baumann (1961) studied outpatients and medical students. Brunswick (1969) compared perceptions of three cultural groups of adolescents between the ages of twelve and seventeen years-of-age. Brunswick (1969) stated that "adolescents are concerned about their health and are able to provide detailed information about their own feelings and perceptions regarding health matters" (p. 1744). These adolescents' perspectives are described in terms of their comparative frequency within the groups; however, descriptive data from the 33 informants is scant. Baumann (1961) completed content analysis on written documents of two groups and found three categories of responses to an open question about being in "very good physical condition: a) a general feeling of well-being... b) the absence of general or specific symptoms of illness... [and] c) what a person who is in good physical condition should be able to do" (p. 46). Although limited, a beginning examination of lay perceptions was provided by these studies.

More recently, Laffrey (1985) reported a study of 95 adults using qualitative data obtained with interviews. She describes a 16-item scale based on Smith's (1981) four categories of health as the conceptual framework, but does not clarify whether the origin of the items is ~~from the~~ qualitative data or the deductive framework.

Lay persons' and professionals' understanding of health differ (Morse, 1987; Spector, 1979). Morse (1987) compared 98 inner city residents' perceptions of health to health professionals' components and reveals not only differing components, but different terms used to describe the "same" component. For example, professionals discussed heredity, the informants did not, and the professionals used the terms self-realization and integrated functioning, whereas the informants talked about happiness and energy, respectively (Morse, 1987). The inner city informants used similar descriptions to those used by the medical students' and outpatients' descriptions in Baumann's (1961) study, and the informants were found to perceive varying degrees of the interaction of mind and body in health. However, data in the first study were based on open-ended interviews, while the second study study was conducted using written answers to open-ended questions.

Although some data are available about lay perceptions of health, often as comparisons with health professionals' viewpoints, considerable gaps exist in our understanding of health perceptions in various groups. This is true of the adolescent subculture.

Two investigators discuss children's conceptualizations of health, based on qualitative analyses of open-ended interviews (Natapoff, 1978; Robinson, 1986). However, neither investigator interviewed children over twelve. Natapoff (1978) concludes that the individual interpretation of the concept of health becomes more complex ~~with~~ the increasing development of the individual.

With regard to qualitative data for adolescents, the only report of the meaning of health to an adolescent population reported in 1969 is lacking the descriptive data (Brunswick, 1969). This study was completed approximately 20 years ago. *Ten* years ago, Hedin, Wolfe, and Arneson (1977) reported 800 Minnesota youth's views about health and illness using a combination of qualitative and quantitative methods of investigation. These data were collected by peer recorders in group discussions. The findings were that health is related to: "activity and energy, normalcy, self-concept, physical appearance, and opinions of experts" (Hedin, Wolfe, & Arneson, 1977, p. 7).

Finally, a very recent qualitative study of 50 Colorado adolescents' views of health needs and health status was reported (Magilvy, et al., 1987). The researchers used semi-structured interviews with primary and secondary informants. The same emphasis on physical attributes "meaning" health was evident. Strategies for health were identified as eating, sleeping, and exercising. It does not appear that the interviews with the informants in this study were indepth, because the use of semistructured interviews limited the parameters of data collection.

Collection and analyses of appropriate data to understand adolescent perceptions of health will help to corroborate, clarify, or refute the Minnesota and Colorado groups' descriptions. In addition, by using a different methodology, such as the private interview, differences in understanding may emerge and more indepth information may be obtained.

Summary

Laymen consider health in many contexts, and diverse conceptualizations of health exist. Subjective reports of health have an important status in the theoretical and empirical literature about health. Because of their cognitive and other developmental attributes, adolescents probably have somewhat different conceptualizations of health than children or adults. The variables described in the literature that appear to be inherent in health perceptions are not clearly understood in their respective contexts and therefore they merit further investigation and analysis.

The Research Questions

Health professionals need the answer to the question, "What are adolescents' perceptions of health?" A study designed to examine adolescents' emic view of health can provide a partial answer to this question. The purpose of this study was to explore the meaning and perceptions of health to adolescents sixteen and seventeen years-of-age. More specifically, the following questions are addressed:

1. How do adolescents describe the concept of health and what are the words they use in relation to health?
2. How do adolescents perceive the structure of the concepts that emerge in their explanations of health?
3. How do the words and categories that make up the perception and meaning of health compare?
4. What are the subcultural themes that relate to health?
5. How do the perceptions differ between the subgroups?
6. What are adolescents' perceptions of that which influences their health status and health perceptions?

Hypotheses that arise from these descriptions and themes are made based on the findings and are presented in the discussion chapter.

III. METHODS

Meaning is culturally and individually determined, and must be considered contextually. Qualitative methods are aimed at discovering meaning in context and are necessary to develop knowledge for nursing practice. Where factors are not clearly identified or understood, qualitative approaches can assist investigators to identify relevant concepts or themes that are culturally accurate (Spradley, 1979). In a practice discipline such as nursing, inquiry must begin with identifying and isolating relevant factors, rather than trying to explain or predict imposed variables (Diers, 1979).

The research question, "*What are adolescents' perceptions of health?*" requires culturally-specific, descriptive information for an answer. Information about perceptions of a subculture of individuals, if detailed and understood well enough, is called *thick description* (Goertz, 1973) Thick description portrays the meaning of an abstract concept within a culture, and may characterize the basis of the actions of the individuals within that culture. Ethnographic research methods are designed to access this type of data.

Homogeneous informants can facilitate saturation of the data, therefore two specific subcultural groups of adolescents were sampled for the purposes of comparison. Both the academically-oriented and athletically-oriented groups were thought to meet the criteria of being able and willing to articulate thoughts on health. Valid, thick description is the goal of ethnographic analysis, and the ethnographic interview can be a source of rich information to build thick description. Ethnographic interviews with key informants are one way that implicit information can become explicit. These approaches were chosen and adapted based on the nature of the research question and the data required and they are detailed in the remainder of this chapter.

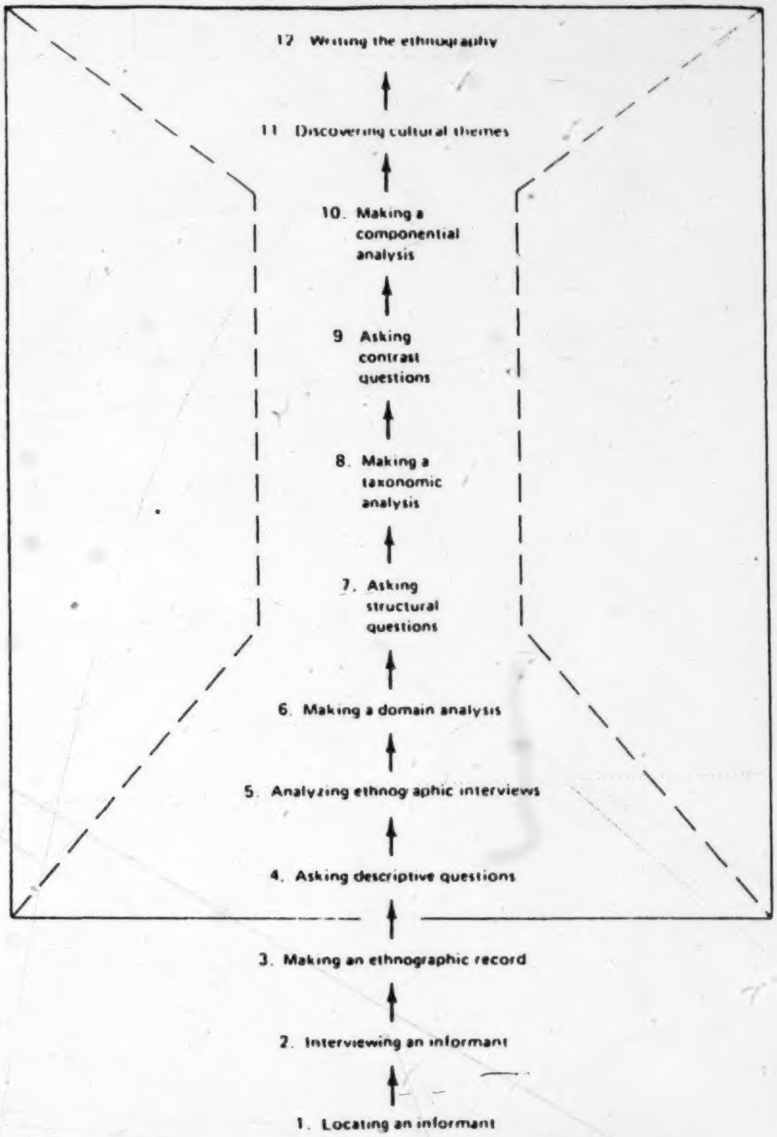
The Developmental Research Sequence Method

The inductive approach is based on the assumption that meaning and perceptions are implicit and can be discovered through the research process. Open-ended ethnographic interviewing and analysis based on Spradley's (1979) *developmental research sequence method* (d. r. s. method) was the process used to obtain, analyze and report the data for this study. The d.r.s. method was selected for this study for the following reasons: a) the research questions can only be answered with descriptive data (Field & Morse, 1985); b) interviews provide a forum for exploring and probing which are required to reach an understanding of informants' perceptions of the abstract concept of health (Spradley, 1979); and c) because some adolescents have the capability and willingness to share their ideas about health verbally with others (Brunswick, 1969; Hedin, Resnick, & Blum, 1980; Hedin, Wolfe, & Arneson, 1977). An overview of the twelve steps of the d.r.s. method is presented in Figure 3.1 (Spradley, 1979, p. 135), and a description of the four types of analyses are presented in Appendix A. The data from the interviews were coded according to the methods described in Field and Morse (1985).

Data in qualitative studies must meet the criteria of *adequacy* (provide quality and quantity information) and *appropriateness* (represent the information related to the question) (Morse, 1986). Proper sampling, skilled interviewing, and ongoing analyses are the key techniques for obtaining data which meet these criteria. The phases of the research process will be discussed in light of their relationship to the adequacy and appropriateness of the data. The data collection and analysis processes are discussed in combination because in qualitative investigations, data analysis begins shortly after the beginning of data collection, and influences the structure and process of data collection.

Sample

Spradley (1979) places "locating the informant" as the first step in the developmental research sequence. Before choosing the informants, decisions about the qualities of a "good" informant must be made. These qualities are related to the nature of the research question and to the culture in question. The sampling goal in this study was to locate adolescents who would provide enough rich descriptive data to allow the investigator to write a valid


12 Writing the ethnography
11 Discovering cultural themes
10. Making a componential analysis
9 Asking contrast questions
8. Making a taxonomic analysis
7. Asking structural questions
6. Making a domain analysis
5. Analyzing ethnographic interviews
4. Asking descriptive questions
3. Making an ethnographic record
2. Interviewing an informant
1. Locating an informant

The D.R.S. steps begin with a wide focus, then with Step 7 begin to narrow for intensive investigation of a few selected domains. The dotted lines inside the box represent this change in focus; they suggest that both a narrow and wide focus occur simultaneously, but with more emphasis on one or the other at various stages of research

Figure 3.1: The Developmental Research Method

Source: Spradley, J. P. (1979). *The Ethnographic Interview* . U.S.A.: Holt, Rinehart and Winston, p. 135. (Used with permission).

partial ethnography.

The informants were required to provide descriptions of their ideas and insights about health (their *perceptions*), as well as verbal explanations of their interpretations and the significance of health (its *meaning*). The investigator judged the appropriateness and quality of each informant during or after the first interview. The qualities used to select and judge whether an adolescent would be a "good" informant were the following:

1. an ability and willingness to articulate thoughts and feelings about his or her perceptions of health,
2. relative comfort being interviewed and tape-recorded,
3. interest in the study, and
4. in general, ease and friendliness with the interviewer.

The informants chosen were sixteen and seventeen years-of-age because it was thought that they would be sufficiently developed cognitively and socially to be able to think abstractly and express these thoughts to an interviewer. Also, this age group was chosen because it is the modal age group of adolescents in secondary school settings. This age range comprises a relatively homogeneous group developmentally, and gender differences are not too great (Mitchell, personal communication, July 23, 1986). By keeping the age range limited, the data were manageable without sacrificing their adequacy and appropriateness.

In order to obtain appropriate informants, a non-probability sampling method was used. Probability sampling *would not* have ensured that the informants would have the necessary and desirable qualities (Morse, 1987). Also, in order to elicit some understanding of variability between subgroups of adolescents, two cohesive groups whose health perceptions were likely to differ were targeted. One group was young people who were very physically active and spent much of their time and energy in physical activities. The other target group involved students who were academically inclined and focused their interests on cognitive learning activities. The informants in these two groups were assumed to be the kind of individuals who would be concerned about their health and take action for their health.

Choosing the adolescents from two subcultures of academically and athletically-oriented adolescents was appropriate for two reasons. First, the individuals from both of these groups had a genuine interest in talking about health and were keen to share their ideas. In the *Canada Health Knowledge Survey* (1984), fifteen year olds with academic and athletic backgrounds scored highest on many various items related to health. The informants in this study were all willing to discuss the topic of health from many "angles" and would almost always continue to explore aspects further with the investigator. Second, the two groups provided some basis for comparison to allow the investigator to keep the possible ranges of view in mind and clarify distinctions between and within categories. There was some cross-over in the groups, but this could be expected. In Magilvy's, et al (1987) report of adolescent health in a Colorado community, the participants identified many *informal* groups and "a teen might belong to more than one group at a time" (p. 38).

Opportunistic sampling, beginning with individuals who are each exemplary in athletics or academics was used with the intention of having these individuals direct the investigator to peers with similar interests, forming a homogeneous subgroup. In opportunistic sampling, the individual selects informants according to the "quality of the relationship with the researcher and the [informant's] ability to articulate and provide explanations to the researcher" (Field & Morse, 1985, p. 94). Knowing the informant in advance as an aquaintance (as opposed to a friend or client) can facilitate establishing trust earlier in the interview situation (Swanson & Chenitz, 1982). Three informants in the academic group were selected through a common friend. The athletic informants were selected by approaching the coach of a swimming team who introduced the researcher to the appropriate members. Subsequent informants were obtained by "snowballing," a method in which each of the first informants is asked to identify someone else whom he or she thinks would be able and willing to provide information about the research question. Since each new informant knew the person who recommended him or her, some trust was established early, and the cooperative phase of interviewing was entered into more quickly.

In qualitative studies the data required, and thus the sample size, varies with the aim of the study and the breadth of the inquiry into the culture (Agar, 1986). The number of informants is also a function of the qualities of the informants *and* of the investigator's interviewing skills because these factors influence the quality of the data (Morse, 1986). For this study there were nine primary informants and two secondary informants. The content of the interviews and the discussion of major concepts became similar and repetitive; therefore accessing new information ceased. That is, data were collected until no "new" categories and interpretations were obtained from the informants (Field & Morse, 1985).

Adolescents, or for that matter all humans, sometimes provide information to others that is different from what they would say to their peers or what they think privately. Concerns about interpreting subjective, perceptual information are therefore compounded by some sociocultural norms, of the adolescent in particular. In addition, sometimes a "researcher effect," (McLaughlin, 1986) or a desire to please the investigator, is present (Dean & Whyte, 1958). Characteristics of adolescents that could have made valid interpretation of the data more difficult were: ambivalence in formal discussions, using metaphors in communication, and hypocrisy. Youth "frequently do whatever is required for personal advancement...[and] for increased status" (Mitchell, 1986, p. 180). The informants actually were not ambivalent about participating, they spoke directly, and it was rare that the investigator suspected that they were not being honest about how they lived in relation to the "ideal." There were times when it seemed that the informants were trying to "please the investigator," however. Awareness and understanding of these concerns minimized misunderstanding of meaning.

Examining the context of the interview situation and the researcher-informant relationship carefully for, as Dean and Whyte (1958) explain, "ulterior motives...bars to spontaneity...desires to please...[and] idiosyncratic factors" (p. 35), increased the investigator's confidence in the interpretations of the data. Record keeping, careful observations and maximized use of clarification in interviewing helped to keep these concerns to a minimum and prevent erroneous descriptions. Talking with secondary informants and using verification interviews (by meetings and phone calls) also assisted in avoiding interpretation errors.

Using Spradley's (1979) d.r.s. method enabled the investigator to provide an ethnography of one aspect (health) of a particular culture (older adolescents). In the following sections the remaining steps of the d. r. s. method and their rationale in relation to this study are described.

Data Collection and Analysis

As stated, the primary method chosen to collect data to write this ethnography was Spradley's (1979) open-ended ethnographic interview. Those undertaking field work to describe the cultural interpretation of a concept or symbol use extensive observations, many interviews with primary and secondary informants, and a degree of immersion into the culture, especially its language. However, Spradley (1979) states that "...it is possible to do a *partial* description of *selected aspects* of a culture by means of ethnographic interviewing (p. 233)." In this study, interview data consisted of descriptions of health and health experience, the meaning of health, and factors seen to relate to health, as opposed to *observations* of health behaviors. Thus, the scope of the data collected was limited to perceptual, subjective data that described the informants' ideas about health.

After locating an agreeable and appropriate informant and describing the study to him or her, written informed consent was obtained from the informant and his or her legal guardian or parent. The parent was also asked to complete the Background Information Sheet. These forms, along with the description of the study, are provided in Appendix B.

The interviews

Informants were interviewed and tape recorded two or three times each. Each interview lasted between 45 and 120 minutes, but usually the interviews were about 60 minutes long. The interviews occurred in various locations. The informant had the choice of location provided that the place was private and conducive to effective audiotape recording. The setting ranged from a seating area in an isolated public place to the informants' homes (livingroom, bedroom, or outside). Twenty-five interviews were tape recorded and and analyzed in the primary collection phase.

Informants were interviewed alone for several reasons. Private interviews facilitated confidentiality, encouraged full expression of ideas, and minimized peer or parental influences on responses to the questions (Hedin, 1986; Hedin, Wolfe, & Arneson, 1977; Morse, 1986; Norman & Harris, 1981). Group interviews would have limited the probing questions that the investigator could ask each informant. Rapport development between the informant and the investigator occurred quickly in the private interview situation.

The context, or tone, of the interviews was an important consideration. For this study, three specific conditions were considered in establishing an appropriate context: a) adolescents, in general, are in a developmental stage in which they demand mutual respect and control (Mitchell, 1986); b) the research question was seeking explanation of an abstract concept from a particular cultural perspective which may be *implicit* in this culture; and c) the ethnographic interview was likely a new experience for all of the informants (Spradley, 1979). A "teach me" posture was used by the investigator to encourage the informant to share details that may have otherwise been overlooked or purposefully avoided because the informant may have thought the investigator would know. In order to make the informant comfortable enough to share his or her ideas about health, a non-authoritarian relationship was vital. Agar (1986) states that the roles in the ethnographic interview are similar to those in a teacher-student relationship. Because these roles have a formal connotation for individuals in this age group, the actual role of teacher/student was consciously avoided to enhance free exploration. The relationship of the investigator to the informant(s), and the nature of the questions were designed to account for these conditions.

The investigator used every opportunity to communicate respect, interest, and acceptance of the informants. By allowing the informants to choose the location of the interviews, they gained some control early in the relationship. The interviews had an informal atmosphere and this seemed to minimize the informant's awkwardness with the interview situation (Agar, 1986; Spradley, 1986). The overall tone was informal, friendly, but purposive.

Spradley's (1979) model of interviewing is based on phases of involvement in the rapport process. There were initial apprehensions of informants in the process and the interview situation was considered from the perspective of the informant. Explanations and responses to questions were given early in the interviews to help the informant learn about the nature of the ethnographic interview, and the nature of the informantion required, that is, detailed information in *their* language.

Interview Questions. The questions in the early interviews were designed to elicit broad, *descriptive* information. Later the questions became more specific to identify the *structure* of the information to the informant. Card sorts and Cantril's Self-Anchoring Ladder (Cantril's Ladder) (1965), described later, were used as tools to facilitate obtaining the structure of the domains from the informants' point of view. Finally, the investigator asked for specific *contrasts*, such as, "What is the difference between fitness and health?" to further clarify meaning.

In Appendix C a list of questions, used as a general guide initially for obtaining data, is provided. The interviews had minimal content structure to allow the informants to identify that information which *they* determined to be relevant to the research question (Agar, 1986; Field & Morse, 1985; Spradley, 1979; Swanson & Chenitz, 1982).

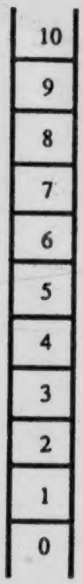
For example, the informants were asked to describe a typical day. The words of the informants were then used in subsequent questions designed to elicit additional specific information related to the individual's perception and meaning of health. Later, the informants were asked to discuss what one does to stay well (a structural question). Finally, in later stages of the rapport process the informants were asked to discuss the relative degrees of wellness among family members, friends, or whomever was significant to them. The discussion of contrasts required that the informant be analytic; therefore, this discussion necessarily came later in the relationship (Spradley, 1979). The focus of the questions changed from descriptive, to structural, to comparative. This shift in questions occurred throughout the individual informant's interviews and as a change in focus over the course of the study. Each type of question was more or less in depth. That is, the investigator asked for broad descriptions, and later asked for specific descriptions, depending on the stage of the rapport process and the content of the discussion.

Card Sorts. During the interviews, cards sorts were used to elicit new data and for structural and comparative data. Dyadic, triadic, and *Q*-sorts were performed. The cards were also used to present components in categories to verify the constituents and determine their relative breadth (Field & Morse, 1985; Spradley, 1979).

After initial interviews with three informants, the content of their discussions were analyzed for phrases that were related to health by the interviewees. About fifty attributes, behaviors, and influences were identified. These words or phrases were written on two inch-squared cards and in subsequent interviews the informants were told how the information on the cards was obtained and the purpose of the sorts. They were then given instructions on how to do the sorts. After each sort, the informants was asked to name each pile and discuss the content and explain the differences between the piles. The investigator asked structural, comparative, and clarifying questions.

In the earlier interviews the informants were asked, "If you had a scale to rate health, what would it be, and where would you be on the scale?" Because the first three informants used a ten point scale, it was decided that a model of the scale would be used to give some focus and structure to questions about attributes and means to health.

Cantril's Ladder. Cantril's Self-Anchoring Ladders (Cantril, 1965) have been successfully used to study the variable of health (McKeehan, Cowling, & Wykle, 1986). The assumptions made in the development of this tool are consistent with the approach for this study and its assumptions; the meaning of things is significant to individuals, in their context at any given time, and meaning varies between individuals (Cantril, 1965). A picture of the ladder is provided in Figure 3.2.



Cantril Self-Anchoring Ladder

Figure 3.2: **An Example of Cantril's Ladder**

For this study, participants were asked to imagine that the ladder represented degrees of health and then were asked, "What would you call the top of the ladder?" and the same question for the bottom. Examples of responses were: "excellent, all-round health, and shows no concern for any aspect of health" or "physically all-round healthy and a couch potato." Then the informants were asked these questions:

1. What would it take to get to a "ten?"
2. Where were you five years ago, then, where will you be five years from now?
3. Think of someone that you know quite well. Without telling me their name, where would you put them on the ladder and why?
4. What would it take for that person to be a "ten?"

The questions referring to another person would be asked several times to encourage a range of discussion. Also, the informants improvised and made the health ladder representative of two "health ladders;" one for physical and one for mental.

In the manner presented, indepth data were obtained to prevent increasing the number of interviews to unmanageable and wasteful proportions. Interview techniques were closely examined by an experienced nurse-anthropologist during the data collection phase, especially at the beginning, and were determined to be adequate.

Other data

In addition to the interviews, data were recorded by the investigator in written form before, during, and after the interactions. The investigator limited writing activities during the interviews to avoid intimidating the informant and to listen more carefully. When listening to the tape recording the investigator recalled details about the context or environment that were recorded in the form of notes or added to the transcriptions. In this study, two forms of investigator notes were kept: field notes and a "diary." Both field notes and diary entries were recorded following each interview and any other time that the investigator thought of something that was relevant to the study.

Field notes of observations, opinions, interpretations, hunches, ideas and areas for further data collection were kept from the time that the investigator started to interview informants and throughout the data analysis process. The notes contained information about contextual and process data that were used to facilitate the analysis process. The field notes included "memos" (Glaser, 1978) or written analyses or insights which are saved for later incorporation into the analysis. The ideas from the field notes and memos were incorporated into the interviews, by structuring subsequent questions, but the investigator avoided formulating and involving developed analyses too early in the study (Swanson & Chenitz, 1982). By the time the fifth informant's interviews began, the analysis was at a level in which the first interview questions were more focused on findings.

In addition to the field notes, the investigator kept a diary to express ideas, problems, and experiences with the research process itself. The information in the diary was used in data analysis to gain awareness and insight about the research process. This information reflected personal opinions and judgements. These data influenced further data collection by aiming the investigator away from invalid or biased interpretations. Thus, including the subjective experiences of the researcher was important for valid interpretation of the informants' understanding.

Analysis steps

Following each interview, the tapes were transcribed verbatim, and non-verbal observations were added and placed in brackets. Analysis began with the data from the first interview. Each interview was re-read two or three times in order to identify errors in transcription, to become familiar with the content, and to identify gaps. For the first two or three informants, the interviews were carefully analyzed, with the assistance of the investigator's thesis supervisor. Specific suggestions were made for minor improvements related to the skill of the investigator and the format of the interviews, and changes were implemented in subsequent interviews.

Spradley's (1979) method involves efforts to analyze the data in different ways in order to "search for parts of a culture and their relationship *as conceptualized by the informant*" (p. 93). The developmental research sequence method is an analysis process designed to reveal cultural meanings used by the informants to explain and organize their experience and behavior (Spradley, 1979). The analysis steps are five, six, eight, nine and eleven in Figure 3.1. The analyses became more focused as more data were collected.

Coding and Sorting the Interviews

In order to facilitate the analysis process, the interviews and selected portions were coded according to the method described in Field and Morse (1985). Each page of the copies of the transcripts were color-coded along the left margin, to enable the investigator to identify which informant's ideas were expressed and during which interview.

The content of each interview was scrutinized and categorized. The relevant sections were cut out of the interviews and taped onto large colored pages (one color for each major domain). The analysis and coding within each domain was initiated when the file of pages became "fat." In this way, categories were derived literally from the data, and themes emerged from grouped quotes and comparative analyses between categories and informants.

All the data, including field notes and the diary, were examined using Spradley's (1979) process of domain, taxonomic, componential and cultural themes analyses. The *domain analysis* identified categories or themes that were evident in the data. *Taxonomic analysis* was for the purpose of identifying the organizing structure of the domains found in the domain analysis. *Componential analysis* resulted in a structuring of the domains or categories of the first analyses with their descriptions for the purpose of identifying the differences (contrasts) (Spradley, 1979). By identifying contrasts of domains, clarity of structure was attained, and as well, themes began to emerge. *Theme analysis* "involves a search for the relationship among domains and how they are linked to the culture as a whole" (Spradley, 1979, p. 94). For further explanation of the steps, refer to Appendix A. All the analyses process continued after data collection and during the writing phase.

Many themes became apparent during the first three types of analyses, but some became evident in the theme analysis only. The emphasis in analysis was on using the domains that were derived from the data in the previous analyses. This building process linked the domains together in larger themes, which is the basis for the description of meaning in ethnography. Relationships among the domains and themes were hypothesised and the data were searched to support, refute, or discover inconclusive areas of insight. Comparative analysis for subcultural group differences was performed when enough data were collected from each group, but detailed comparisons were done at the end of collection. The differences were discussed and verified or refuted by the secondary informants and primary informants in verification interviews.

Summary

Spradley's (1979) ethnographic process was used to guide systematic and thorough examination of the cultural meaning and perceptions of health according to the nine adolescents in this study. Each step involved writing descriptions which later comprised a portion of the results of the study. Although the process was used during and following the data collection phase, a re-analysis was done during the writing phase. It is thought that the quality of the interpretations increased with the process replication and thus the validity of the results were increased. The following chapter presents the informants' responses to the question, "*What are adolescents' perceptions of health?*"

IV. RESULTS OF THE STUDY

The nine primary informants in this study explained their ideas about health and these data form the content of this chapter. First, background information about the adolescents who participated is presented. Then, following an *overview* of the concept of health, the characteristics of, and the strategies for, health are presented. Taxonomies were developed in order to clearly and accurately describe the components of health. The text includes descriptions of the adolescents' ideas, and verbatim quotes will be used in order to capture the essence of the adolescents' perspectives. In the quoted segments, comments and questions from the investigator are placed in square brackets.

Next, the analysis of those factors that are perceived to influence the adolescents' ideas are presented. The cultural themes that emerged from the analyses of data will be discussed as they relate to the structure and processes of health. In addition, any differences noted between the subgroups of informants' ideas will be described.

The Informants

In Table 4.1 some background information about the nine adolescents chosen as informants for this study is presented. Six informants were sixteen years-of-age and three were seventeen years-of-age. One informant was in the tenth grade, six were in the eleventh grade, and two were in the twelfth grade. There was some cross-over of the groups: five informants who were chosen on the basis of their athletic orientation were all committed swimmers, and two of the "athletic" individuals stated that they had grades that were similar to those of the academic group, and three of the academically-oriented individuals described themselves as avid participants in one or more physically demanding activity (eg. ballet, running). Thus, the groups are not clearly distinct. In addition, two secondary informants (both male and from an academic background) were involved in two interviews during the final stages of analysis.

Table 4.1: The Primary Informants

Group Affiliation	Male	Female	Total
Academically-Oriented	2	2	4
Athletically-Oriented	3	2	5
Total	5	4	9

According to the background information sheet from the parents, none of the informants had ever had a chronic disease or serious illness. Four of the informants had a close relative who had a serious disease or had died from a disease. All of these individuals spontaneously discussed the relative and his or her illness in the interviews. All of the informants were articulate and able to think about and engage in abstractions related to health; they were able to express ideas for more than three hours of interviews.

The primary informants, sometimes spontaneously, rated their own health. On a scale of one to ten the ranges were from 6.5 to ten for physical health and six to nine for mental health. These "healthy" informants explicated their ideas about health to the investigator, and the following paragraphs present the details of their views.

An Emic View of Adolescent Health

The translation of an emic view of health which follows was developed through analysis of the adolescents' discussions of what health meant, their experiences of health and illness, how they promoted health and what factors influenced their health, including how they learned about health. Early in the interviews many of the informants offered a definition of health such as: "it's a combination of everything someone does in their life to contribute to good living habits;" "everything has to be working properly and you give your body what it needs. . . food. . . rest. . . and exercise;" and "health is partly happiness or contentment." Health was described as an experience, a value, a goal with subjective criteria, or as a means to attain goals in life.

Health was defined from an experiential perspective (how one feels) or a functional or adaptive perspective: "being able to make it all the way through the day (laughs) without collapsing!" Most of the informants stated that one way that they experienced health was in its absence, that is, when ill. One informant started off by saying, "I've always thought of health as being the opposite of sickness and that's about it."

Most of the informants stated that they had "never really thought of health before." "I honestly don't use the word very often. It doesn't come up in everyday conversation." Some informants told the researcher that the discourse in the interviews was a process of developing their ideas of health rather than purely presenting the ideas that they already had. The informants said that they thought about health infrequently between interviews even though the researcher had suggested this to enhance subsequent discussion.

When the informants were asked what words they and their friends used in talking to each other about health, the informants referred to the topics of diet and exercise and body build, or a feeling, "I feel great, loose, happy." These adolescents have no other labels in their subculture that directly represent health, but with probing the range of vocabulary seen by the informants to be related to health was broad.

The informants could not explain why they thought adolescents did not spend time thinking or talking about health with others: "I rarely think about it, I don't know why." One informant volunteered that she thought that the lack of discussion might be related to an embarrassment about some topics related to health: "I think some people are afraid to talk about health things because they are embarrassed.... Like about sex and AIDS....You can talk to a few close friends about it." Embarrassment was also identified as a factor by adolescent participants in a study about health attitudes and beliefs (Hedin, Wolfe, & Arneson, 1977).

Discussion about fitness and weight was plentiful and self-initiated; however, when the informants were asked to explain other aspects' relationships to health, (such as "learning something new"), the informants seemed to have less to say. Despite these observations, the adolescents articulated many opinions and insights about health in their words and from their point of view.

Invariably health was described to have both a mental and a physical component which were "intertwined." Social, moral and spiritual health were presented as types of health by one informant, but he also stated that they were subsumed under mental health. Although references to the body and mind were made often when referring to aspects of health within mental and physical health categories, the terms body and mind were not used by the informants to describe the categories (that is, as "cover terms").

Physical health was seen as the body's condition and ability. One who is physically healthy was fit and strong, and had energy, endurance and resistance. One informant made an analogy between the body and a car:

> For your car you have to keep it tuned up and running - everything has to work and if everything's working out, like then that's how the body is, you have to keep everything working well.

The person who was physically healthy was able to do many different activities, especially physically demanding activities. The informants varied little in their descriptions of physical health.

Mental health was described in broader, more abstract terms. One informant said that this was because "mental health seems harder to pin down than physical health." Some informants from both subcultural groups referred to intellect and thinking ability as aspects of mental health, but also included a broader context when discussion was encouraged. "I thought that mental health took in everything that physical health didn't.... [I]t's the health that has to do with the mind, ...emotions, ...and in your perceptions." "Mental health could be defined then as being calm in almost any situation taking place." Although the informants used many words to describe mental health, the taxonomy has few descriptors that relate to mental health because the informants, while doing the card sorts, stated that many of the terms were redundant and they "overlapped."

Every informant related physical health to mental health and vice versa. The informants described some physical health attributes that were seen to have emotional implications and some mental health attributes were described to have an impact on physical health. "If you are physically sick you are emotionally run down." "Also, if I don't get enough sleep I just can't function mentally as well." According to these adolescents, there was an interactive relationship between the mind and body.

In describing their *experience* of health, the informants referred to a state of effortlessness and well-being. Being alert, energetic and tireless was how one felt when one was healthy. They stated: "you just feel like you could swim forever," "things come naturally," and they reflected that one enjoys oneself, and has a positive response to things. The person who was healthy "feels happy, looks forward to doing things" and "sees things they like about themselves." The words used to describe the exprience of health were in contrast to the words used to describe the personal experiences of illness.

One informant described the experience of health as feeling "laid back," especially in response to stressful situations. Most of the informants expressed this as "no worrying" or "not (being) uptight" and that one was "ready to grapple with whatever." Inherent in the experience of health was a sense of managing and coping. In summary, *health was described as adding a quality to life experience,* and *enjoying life and having positive emotions represented health experience.*

When discussing the experience of health the informants used words and phrases that reflected a broad sense of enjoyment and well-being. When directly questioned about this, one informant stated, "health to a lot of people is very abstract...that Big Thing," and another said that "everything I do seems to relate to health, but in some weird way that you can't explain." Health was all-encompassing and not easily distinguished from other states and processes for these adolescents. "Everything from the very beginning of the day is related to health." The purpose of the next two sections is to categorize and represent the structure and process of this "everything."

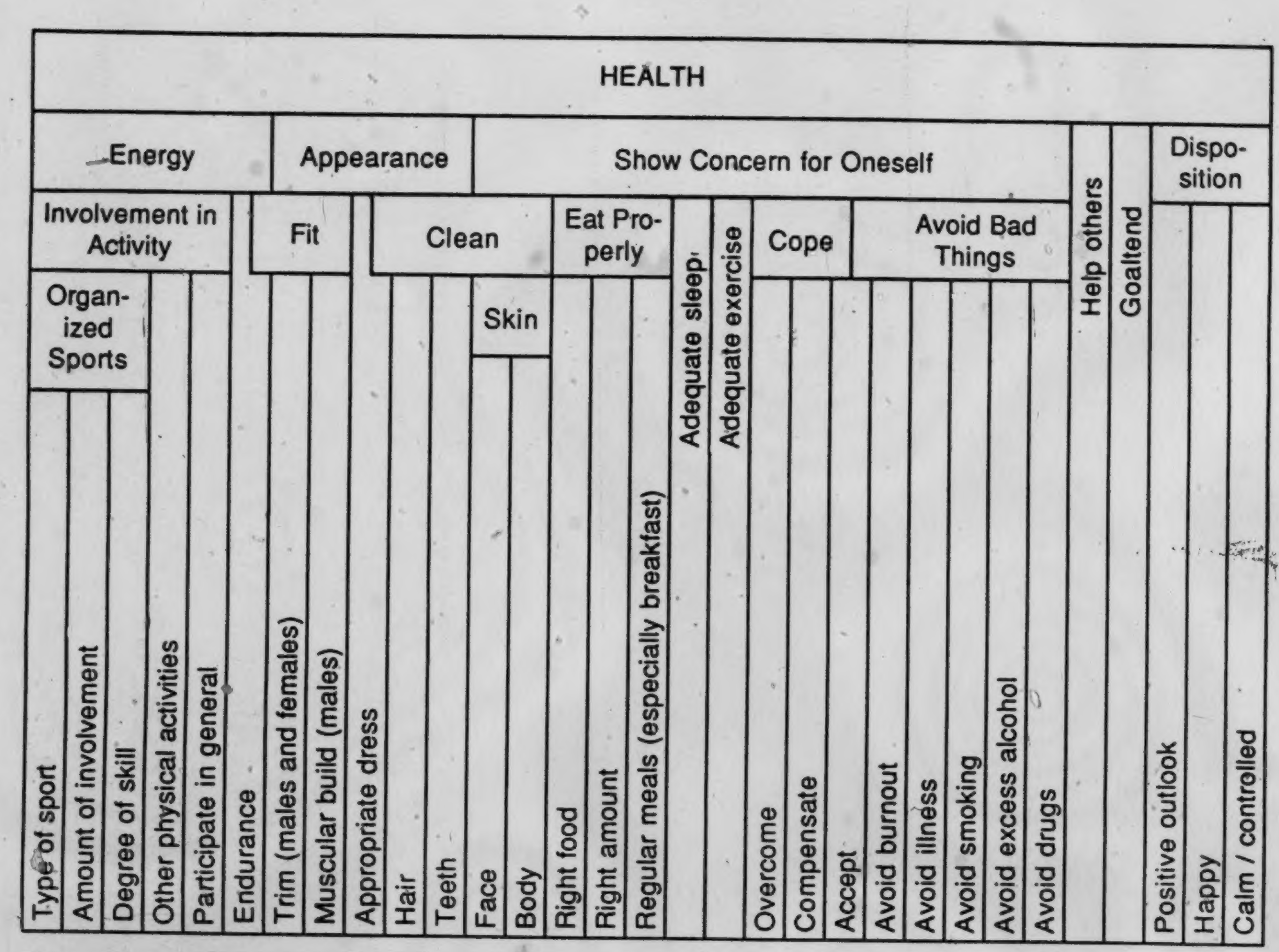
In order to add to an understanding of these adolescents' emic view of health, the informants were asked to identify those *characteristics* that would indicate that someone was healthy. This structural question was asked in many different ways. For example, the investigator used card sorts and Cantril's Self-Anchoring Ladder (Cantril, 1965), and the investigator initiated and processed discussion on the absence of health. In addition, informants were asked to rank different acquaintances' health, and then, to rate and compare descriptions of people presented by the investigator. "Aspects of a healthy person" was often described spontaneously and chosen as a category by the informants when doing the *Q*-sorts. From the analyses of hundreds of implicit and explicit comments from the nine informants' descriptions of the characteristics of health, the Taxonomy of Health was developed. It is presented in Figure 4.1.

The Taxonomy of Health Characteristics

The words in the taxonomy are primarily those used by the informants. In some cases, however, other terms have been chosen by the investigator to enhance clarity and to most accurately reflect the picture of health that the informants presented as a group. For example, *goaltend* was not a verb used by any informant, but was chosen in order to encompass the essence of the discussion related to goals as one aspect of health.

Although the informants discussed manifestations of physical and mental health, when asked they were unable to clearly distinguish the characteristics related to each group. Mental health was reflected in physical health.

> Like you get people that...don't have a lot of friends, and like you can sort of tell, like they sort of don't worry about their hair or anything like that, you know? Or their clothes or anything. So I think that can sort of apply to both (physical and mental health).



- HEALTH
  - Energy
    - Involvement in Activity
      - Organized Sports
        - Type of sport
        - Amount of involvement
        - Degree of skill
      - Other physical activities
      - Participate in general
    - Endurance
  - Appearance
    - Fit
      - Trim (males and females)
      - Muscular build (males)
    - Appropriate dress
    - Clean
      - Hair
      - Teeth
      - Skin
        - Face
        - Body
  - Show Concern for Oneself
    - Eat Properly
      - Right food
      - Right amount
      - Regular meals (especially breakfast)
    - Adequate sleep
    - Adequate exercise
    - Cope
      - Overcome
      - Compensate
      - Accept
    - Avoid Bad Things
      - Avoid burnout
      - Avoid illness
      - Avoid smoking
      - Avoid excess alcohol
      - Avoid drugs
  - Help others
  - Goaltend
  - Disposition
    - Positive outlook
    - Happy
    - Calm / controlled

Figure 4.1. The Taxonomy of Health Characteristics.

This idea that many characteristics of health, especially observable characteristics, could reveal both physical and mental health was so commonly stated and related to so many characteristics that no distinctions are made about mental and physical characteristics in this taxonomy. *In general*, this taxonomy flows from left to right as being more reflective of first physical and then mental health, but to these informants, clear distinctions could not be made.

The first levels in the taxonomy represent the major categories that the informants used in describing characteristics of health. People who were healthy were described as having energy, looking a certain way, and doing things to take care of themselves and others. Healthy people were seen as having goals which they worked toward and ultimately achieved. In addition, healthy people were viewed as having a certain disposition. Each major category is described below.

Having Energy

Having energy was the primary behavioral manifestation of health. The informants described the healthy person as being active and involved, and having endurance. The academic informants described someone with energy as one who manages many things *and* has the physical energy to be involved in activities; the athletic informants focussed on the latter part of this description.

Involvement in Activity. Activity was most commonly referred to in terms of physical participation in sports. One manifestation of energy was described as being involved in "organized" sports. A person's health was judged by the amount of involvement and the type of sport that the person participated in. This distinction was made by both groups of adolescents but with particular emphasis by the athletic informants. One athletic informant said, "I think more people respect the decathalon person because they (sic) can do more things and they're (sic) better at more things, they're (sic)...in better shape too." An academic informant said, "I don't think (I'm a ten in health) because I like a lot of sports and I'm good at them, but I'm not really excellent at any one." In addition, the degree of skill in a sport was important. Those who excelled in a sport, for example, participants at a Provincial or Olympic level, received higher health ratings. Involvement in any physical activity, from playing frisbee to shovelling the walk, was considered in judging health status.

The informants went even further to state that involvement in *any* activity was a healthy attribute -- "even chess" -- characterized health in a person. "Like you take interests...or else you just sit around and become a couch potato! (laughter)" One informant stated that statements about intending to do some activity, "I feel like...." or "Let's go and...." (fill in the blank), represented health. Another informant said, "there's a lot of different activities that go from mental to physical to social -- anything like that (will contribute to health)."

The final characteristic that represented having energy was "endurance." This was seen as one's ability to withstand physical activity: "if he was puffing and wheezing coming up two flights of stairs, carrying his books to the next class...obviously that is a "two" or a "three" (out of ten)." Academic informants tended to describe energy and endurance more in terms of one's "spirit" of participation. "Having the endurance and energy...and having the frame of mind to go along with it." Both groups of informants expressed these views but, the athletic informants emphasized the action aspect. Endurance was described by both groups as an indication of one's fitness level and was also used to describe the quality of *being* fit. Thus, endurance as a trait revealed qualities of both energy and fitness, both of which represented health.

Appearance

Appearance is the first indicator of a person's health. "I mainly judge [health] on what a person looks like." These adolescents claimed to make assumptions about a person's mental and physical health based on appearance.

> Well, like how they look -- like you can tell that they -- like their face. It's not

> all splotchy or anything, and you can tell they look after themselves and eat right.
>
> If you look healthy then you project this image of a healthy person, that you have some self-respect. ....I mean just by looking healthy then you...people think the person is concerned about themselves....and if they like to take care of themselves, they can probably be trusted to take care of other things, handle greater responsibilities.

The adolescent emphasis on appearance and acceptance was entangled in these adolescents' ideas about appearing healthy. One informant said, "We're certainly all pretty caught up in appearance, and so appearance is the first big impression that someone makes."

The criteria used to judge healthy appearance were described as being fit, being trim, dressing appropriately, and being clean. One articulate informant reflected the consensus of the group:

> I guess to most people the first impression is most important. It is combined with what you wear [and] the way that you wear it. Often if you wear big baggy things, it kind of hides your form, which is another image, it proves to people that you are healthy if you are reasonably skinny. So I guess clothes first of all and then their height and weight...the way a person is built basically. If they look really scrawny or if they are really fat then they don't look very healthy, so I always try to stay slim. What else?...The way a person wears their hair, accessories. If the person looks clean, I have a shower every day, wash my hair every day, I brush my teeth every day, I guess that projects onto a person's fragrance. If a person smells or if they don't.

Looking Fit. Being "trim" or "slim" was identified as a feature of a healthy person because body tone was seen to reflect many things: proper eating, exercising, having self-respect and being a person who has "got it together." Weight was used as a criteria in judging a person's health, even for someone who was in a wheelchair! One informant stated that "almost every adolescent worries about their weight." Another said, "I have the attitude that if we're fat, we're a one, or even a zero (out of ten)."

Some important qualifications were made regarding being overweight. The informants agreed that one would have to be *obese* to be considered unhealthy, and that thinness was more ideal. When asked how many pounds overweight would be considered unhealthy, both groups of informants suggested a number of pounds ranging from twenty to twenty-five. The person would be otherwise considered just "chubby." Athletic informants said fifteen pounds overweight was "okay" while the academics went up to twenty pounds. Two informants mentioned being underweight or "anorexic" as a negative factor in judging someone's health. The other informants felt that being underweight could be a health problem but viewed this as less serious than being overweight.

This idea of a minimum and maximum with an optimal point was a theme that the informants applied to characteristics of, and strategies for, health. One informant, who's code name was "Rusty," described a curvilinear relationship of some variables, in this example, exercise, to health:

> I think you have to reach that moderate point where you're going to perhaps reach that level of maximum level of life expectancy, and it varies from person to person due to personal circumstances, you know, heart problems or something like this. But if you take it too far then you're...it's kind of like a triangle, if you're down...and you're not healthy or whatever, then you don't have that high of life expectancy as you get more healthy, you get to that moderate point where it is the best for you the amount that is the best for you of exercise and stuff like this. And then you reach maximum life expectancy. But once you go over that point you start to descend again....

This theme was designated as *Rusty's Triangle*. The attributes or strategies were the equivalents of a dependent variable in a curvilinear relatioship. The important idea presented was that attributes of or strategies for health related best to health in moderate amounts. The variables listed as applicable to Rusty's triangle were: exercising, eating, sleeping, stress, worry, and weight. The informants conceptualized these aspects in degrees, and moderate amounts were best. As an example, the curvilinear relationship of weight and health is represented in Figure 4.2. The descriptive terms in the figure are those used by the informants.

In addition to considering the number of excess pounds in their interpretation of what was overweight, the informants stated that the degree of overweight was *subjective*, that it would partly depend on the person's build and opinion of themselves.

> They'll (magazines) say that the only way you're going to be physically fit is if you weigh this and if you weigh that, or if you look like this. I know that's impossible for everybody, because everybody's individual and different.

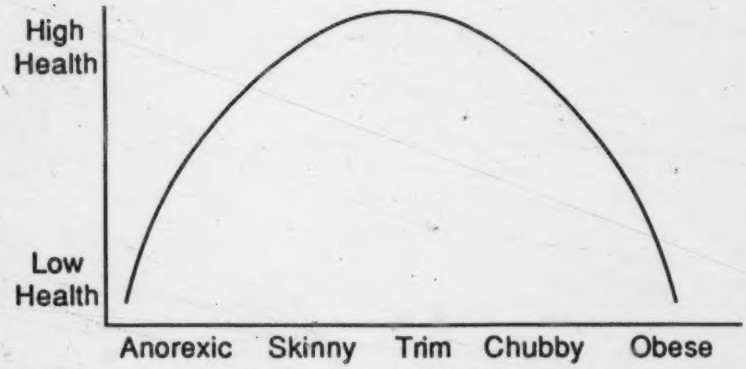


Figure 4.2: **Rusty's "Triangle" - Weight and Health**

> It depends on what *they* think about how overweight they are, it depends on your frame, height and age.

Also, three of the informants (one academic and two athletic) described the relationship between muscle and fat in relation to weight. They claimed that stating numbers of pounds to describe obesity was not as good as looking at a person's build and shape.

In judging males' health, having a large, muscular build was identified by the male informants as a manifestation of health. The female informants acknowledged that males seem to be "concerned about their muscles" but did not describe it as a quality that they use for "scoring" the health of males. This was the sole difference noted between the male and female informants' descriptions of health.

In summary, weight and body build manifested a person's health because it reflected the person's concern for looking good and the person's self respect. Being trim and fit were ranked as equally important by the athletic and academic subgroups and the male and female subgroups. All informants saw weight as being representative of mental *and* physical health.

Dressing Appropriately. Another characteristic of a healthy person was how one presents oneself. However, clothes, accessories and hairstyle were described as the *least* important of the criteria related to healthy appearance. One informant denied that clothes had anything to do with health. However, his comments were in the context of resisting peer norms, and norms about one's style of dress was seen as one outside force to resist.

To the others, having the right clothes meant being accepted. Wearing "revealing" clothes demonstrated a confidence in oneself that indicated health:

> "...and I guess how they dress, like, they're not afraid, like they wear their clothes and they're not afraid to reveal themselves a bit, like say, wearing tight pants or something."

In addition, a healthy person wears *clean* clothes.

Being Clean. Appearing clean was also described as an aspect of health. Having clean hair and teeth were specifically noted as manifestations of one's health. Clean skin was presented in terms of acne (clean face), body odor and clean clothes (clean body). These aspects were all related to physical *and* mental health manifestations.

> [You talked about having a shower [as being healthy], is that physical health?] I guess it is kind of the bridge between the two because part of the mental part is having the self-respect for yourself...if you have the self-respect to keep yourself clean...um,..the manifestation, the physical manifestation of the mental health, I guess.

> You just don't want to appear as, you know, I don't care about myself - come to school with your hair all messy, or you know, it doesn't look like you showered that morning or something - you smell. Not a nice thought.

> You see a person who's got blemishes all over their face...you may think that they don't care what they look like...they obviously don't take care of themselves.

Factors related to appearance and energy were the first two groups of health aspects mentioned.

In summary, the informants estimated health by one's appearance and the activities one participates in. According to these adolescents, in order to be more accurate and obtain more than a superficial assessment of someone's health, "you could spend a day with a person." The following criteria of showing concern for oneself, helping others, goaltending and the nature of one's disposition were presented as those aspects that one would explore further, as health indicators; thus these criteria partially represent the concept of health the way the adolescents in this study conceptualized it.

Showing Concern for Oneself

The next category of characteristics that the informants thought of as health was a group of behaviors that signified "showing concern" for oneself. Being clean was described as part of a healthy appearance and part of showing concern for oneself. Also, the adolesents said that how clean one is, how one eats, copes, and the actions that one takes to avoid "bad things" signified concern.

Eating Properly. One's eating habits was another criteria used by the informants to rank a person's health status. The informants offered varied descriptions of what types of food were appropriate. One informant thought pizza was "junk food," because it was "fast" food; another noted how pizza was healthy because it had all the food groups incorporated into it. Another informant thought that any bought and prepared food was bad, but home made cake, etc. was healthy. Eating sweets and chips, etc. was acceptable and did not affect one's health rating *if only done on rare occasions*: "once in a while you deserve a treat."

The informants referred to eating ***enough*** as important for health. Both the athletic and the academic group described proper nutrition for most people as the "four food groups in the right proportions," but the right number of calories or amount of food was determined subjectively. For example, athletic informants all described themselves as being less healthy when they were not eating a high calorie, nutritious diet.

Finally, eating regularly, especially breakfast, was described by the informants as a behavior observed in a healthy person; it demonstrated a characteristic of one who takes care of him or herself. The informants' opinions about proper eating differed significantly; they all felt knowledgeable about nutrition, and they all thought that *their* interpretation about qualities of foods was correct. Even though they felt knowledgeable and that they had learned a lot about nutrition in school, there were some misconceptions in their ideas, for example, an informant said that homemade cake was more nutritious than "bought" cake. Learning about health was somethimes described as lectures on proper diet. One informant said, "Eating well...the four food groups of course -- just rammed down our throats in school!"

Adequate Sleep and Exercise. In addition to eating, the informants referred to adequate exercise and sleep and rest as important qualities of health. Someone who has had adequate sleep was described as looking healthier: "he looks like he's alert and awake, he's had enough sleep." Another quality that implied health was getting up early in the morning. Generally, "a lot of sleep," but not so much that one withdraws, was considered to be optimal. Sleep was another criterion that was placed as a variable in *Rusty's Triangle*, because of it having a range that included an optimal level for health.

Exercise was presented earlier, as a *quality*, of energy. In this context exercising displayed some concern to take care of the body. When asked, "How much exercise is enough?" the informants had no definitive answer. Some informants presented a minimum amount of exercise: "a minimum of three times a week for twenty minutes," but most said something similar to what this informant said: "If he's a couch potato, then going for a walk would increase his health score, and would be enough for him."

This reflected a principle used by these informants in some of the discussions about activity, weight, and several other characteristics. This was labelled ***the principle of subjectivity***, that is, considering what was appropriate for each individual rather than imposing an external rating. This was how informants explained how much exercise was adequate. These adolescents were being careful not to impose an external rating on a person. This was especially true for the athletic informants who saw themselves as extremely fit in comparison to others and were careful not to appear too biased or ostentatious. However, the ***implication*** was that one must exercise a lot to be seen as a healthy person. Exercise was also placed as a variable in *Rusty's Triangle*. That is, more exercise was better, as long as it was not to an extreme.

Coping. The next characteristics of health that manifested concern, encompassed by the cover term "coping," were stated less explicitly by the informants. Healthy people were described as being able to circumvent or manage problems in their life with little difficulty. The informants thought that healthy people coped by overcoming, compensating for or accepting problems. *Overcoming* problems involved day to day crises and upsets, including illnesses. "If you look at it positively, and overcome everything, then you're healthy." If "[one] can figure out problems that [one] face[s] day to day [and one] can solve them...easily," then one demonstrated healthy behavior. *Compensating* physically and mentally in response to a physical health problem was also described as an attribute of a healthy person. In response to the question, "Does being in a wheelchair lower a person's score?" the informants said:

> I wouldn't think so. Because...if your legs don't work, I don't think I'd take off a mark because chances are, your arms are going to work double as well.
>
> As long as he's doing what he likes to do and feels good about it, then he's healthy, even if he can't run around.

In addition, a person who *accepted* things as a method of coping was viewed as healthy. Health was described as "happiness, or at least acceptance" of what you have.

> I really admire people who are healthy, like the boy in my school (with a physical handicap), they (sic) have to overcome that, or at least accept it if it can't be changed.

The informants saw acceptance as a quality of someone who would be able to cope well, someone with an ability to prevent undue stress.

Avoiding Bad Things. The final category that these informants described as showing concern for oneself was avoiding "bad things." One who accepted things was categorized between coping and avoiding behavior because one who accepted things not only coped, but demonstrated the ability to avoid unnecessary stress. Burnout, illnesses, smoking, excess alcohol, and drugs were identified as other "bad things" that healthy people avoided.

> Would they rather, if they were given a choice of going hiking in Jasper for a weekend or staying with a friend whose parents are out of town and partying all weekend, which one they'd choose.. That'd be a question that I'd like to ask.

> Are you going to drink, or are you going to decide on a sport or an activity?

> Smoking, it just sort of gets on my nerves.

Conversely, one informant said it was expected that young adults do *some* bad things, and that it was fun to experiment a little:

> I think that a lot of people are interested in abusing their health or kind of testing it or something like that...It's kind of thrilling to do something that's bad for you...when you know you're going to come out of it--like, I guess it's like going to see a horror movie just so you can scare yourself.

These informants stated that some of the "bad things" were acceptable in moderation. Moderate amounts of stress in one's day to day life and some alcohol intake were considered to be an acceptable aspect and behavior in a person. This quote reflects most of the informants' views about alcohol:

> [How about alcohol, is there an acceptable level of alcohol intake?] Oh yeah, like if it's just, say it's a celebration with your family, I guess it wouldn't be too bad to have one glass, like one or two drinks...like if you go to a party and drink constantly all night, it's not too great....Like if you have it every day it just is terrible.

One informant said that "even drugs can be beneficial at times, they release a certain amount of stress." The other informants said that drugs in any amount was unacceptable or that "none is better."

The idea of burnout was presented by both subgroups of informants, but the examples differed. The academic informants' examples related to working too hard on projects and schoolwork without getting enough sleep, while the athletic informants referred to too much physical exertion without obtaining adequate rest. Both groups felt that someone who took action to avoid burnout was healthy.

Someone who consciously avoided illness and was rarely ill was seen as a healthy person. As will be described later in *Strategies for Health*, just *how* one avoided illness was poorly understood. Two of the athletic informants felt that healthy people *ignored* illnesses, such as a cold or an ear infection:

> I've had an ear infection....the doctor ordered me to stay out of the water for a week, I stayed out of the water for one day and it drove me nuts. I had all this time on my hands, and I certainly didn't want to do *homework* so I just got in the water anyways...it started to get worse as I went along, but [I] just ignored it and it calmed down. [Did you go on antibiotics?] No, I didn't. I just let it run its course...my mental attitude seems to have worked.

The athletic informants had slightly different standards for "showing concern for oneself" when it came to performing in their sport.

The academic informants stated that a healthy person responded to minor illnesses by taking care of themselves and controlling the symptoms. This contrast seemed to be related to different beliefs about illness: the two athletic informants felt that minor illnesses were related to stress buildup and that releasing the emotions by continuing activities would be the best strategy for decreasing stress. The academic informants all thought that illness was from decreased resistance and that resting was an appropriate self-care behavior that showed concern.

In general, academic informants had broader and less subjective ideas of what constituted showing concern for oneself than athletic informants. Athletic informants mainly emphasized observing exercise and eating behaviors. However, both groups acknowledged that "showing that you care about yourself" was a *basic manifestation of health*:

> Health is having a definite concern as to what an outcome will be...to be healthy, you have to care.

> You lose physical health because you're not happy or you're not healthy in your mind, and you stop *caring* (her emphasis) about being healthy in your body.

> I think health is basically decided by your attitude on life and the value that you place on it. If you're gonna place it as important, it doesn't matter if you can't walk, if you can't talk, if you can't see, you know you can still be healthy and if you have a very poor attitude and *you don't really care any more* (emphasis added) 'cause something like this happened to you...then you can be right down at the

bottom of the scale....

The informants agreed that adolescents, in general, care about themselves, *but they rarely reveal their concern:*

> I think they keep it to themselves and take care of themselves.
>
> A lot of people are more cautious with themselves than they like to seem.
>
> A lot of them take health more seriously than they seem to.

It was evident that health was important to these individuals, and that they knew some strategies to care for their health. However, their words described a conspiracy by adolescents to mask the concern.

Helping Others

Another criterion, "helping others" was also seen as an attribute of a healthy person:

> It is healthy to want to contribute something greater to the world as well, not just to satisfy yourself, but to satisfy and add to the greater community as well.
>
> A healthy person seems to be someone who is healthy enough themselves that they can help other people or they can worry about other people who need help to be healthy.

Helping another was seen to represent physical and mental health. The informants did not elaborate on this criteria, even when prompted; some of them seemed almost embarrassed to mention that they were helpful. Mostly they wanted to talk about how others had helped them.

Goaltending

The next criterion that represented health to these informants was the behavior which has been labelled *goaltending*. Goaltending is defined as having goals, working on goals, and achieving goals. People who had objectives, worked on projects, and achieved goals were seen as healthy. "Working towards something, you're committing yourself...it just seems to me to be a very positive aspect in someone." One informant's comments summarized the abundant discussion this way: "Obviously if you have goals you have a willingness to live." Goaltending was seen as a healthy attribute, one of taking on a challenge. Descriptions of healthy people included phrases about goaltending such as the following:

> She is probably more happy than anyone in the group...like she has a goal.
>
> He's very involved in a lot of aspects of life.
>
> She's been working on them...she can look at it (sic) and say, "Yes!," she's accomplished something. So she's more healthy than somebody that says, "Well, I can't do *that*!
>
> I consider it a healthy attribute of someone if they are working towards (goals).
>
> People with no goals or direction, it's kind of depressing.

Both the academic and athletic informants emphasized goaltending; however, there were differences in their examples. Athletic informants referred to exercise and nutrition-related goals. The academics also used fitness and nutrition as examples but they included a range of types of goals, such as learning something new. Another difference in the two groups' examples was that the athletic informants' goals were result-oriented and the academic informants tended to give examples of goals that emphasized their motivational qualities and were challenging. When the informants were asked if having *any* type of goal was healthy, they all indicated agreement. Goaltending is presented in more detail as a strategy for health later in this chapter.

The Nature of One's Disposition

The final category of healthy characteristics were included under one's "mood" or disposition. The healthy person was described as controlled, positive, and happy.

> If you're psychologically healthy you'd think positively, or you do things that are positive.

> He's always in a good mood...he's always there to cheer you up...he's an eight (out of ten).

> Being at peace is a sure sign that someone is emotionally healthy.

> (Health is) having some resistance to the little pinpricks of life.

Differences between athletic and academic groups were not distinct in this area. Academic informants tended to use more psychological terms, such as "at peace," while the athletic informants used more common descriptors, such as "happy." Each informant described the healthy person as positive or happy, not necessarily "bouncing up the stairs to class" but in a "good mood." Happiness was equated with health by some informants: "As long as he's happy, then I say he's healthy." This informant was referring to someone in a wheelchair.

Being calm and controlled, that is, in control of one's emotions and reactions, and being able to "handle anything" were qualities of a healthy person. The essence of these high expectations with regard to emotions is captured in several informants' quotes:

> [A healthy person is] able to stay calm under a stressful situation.

> [Health is shown by] controlling your emotions...don't get too upset...how one reacts to situations.

> Ask - do you get mad easily? Are you bad or ill-tempered that you can't do something?

> Having some reign over your feelings is a manifestation of health.

> No fly-away emotions.

> If you're completely unstable in your emotions, then I don't think I could call you healthy.

The following quote describing one informant's father's health represents the demeanor of a healthy person as described by the group of informants in this study: "He really enjoys (life) too, which I think is a sign if you're in top health. And also, he's quite firm mentally."

Finally, although physical attributes revealed the mental health status of a person to these adolescents, the mental attributes do not reveal much about one's physical health. "You can be fit but inside be a total mess of wires...you can't see a mentally healthy person's heart and lungs and insides." However, it was *generally* agreed that mental health preceded physical health; therefore, physical health attributes revealed much about a person's overall health.

The characteristics of health identified by the adolescents in this study were surprisingly similar between the groups and across individuals. The main differences were in the emphases. Many of the attributes of health appear in the next section, *Strategies for Health*. This is because, as one informant stated, "many aspects are a *sign of* and a *way to* health" (emphasis added). The following section builds upon the adolescent view of health by describing what these nine adolescents said were the strategies for health.

The Taxonomy of the Strategies for Health

The largest amount of discussion time in the interviews focused on means of "improving" or maintaining one's health. The strategies related to these processes were more explicitly stated by these informants than the characteristics of health. The informants often described the manifestations and processes of health simultaneously; that is, they were highly interrelated and sometimes it was difficult to determine which comments were applying to which component of their conceptualization.

Many strategies for the "process of health" were volunteered by the informants with little direct questioning. Some of the strategies for health were described as "the basics" and the other strategies were seen to contribute to progressing beyond the minimum criteria for health (improving). "There's definitely a lot more to [health] than sleep... not eating too much...or something like that. There's millions of aspects...." The discussions, Cantril's Self-Anchoring Ladder (Cantril, 1965) and the card sorts provided a rich data base of these informants' perceptions of the various means for promoting health. From these data, the

Taxonomy of the Strategies for Health was developed and it is presented in Figure 4.3. The process data that related to these strategies for health are presented in the following text along with the respective categories.

The informants discussed processes of becoming, maintaining, and improving health, and many of the suggested strategies were aspects of more than one process. Means for protecting and compensating were discussed but they had a more limited scope. Because there was little agreement about which strategies were for which exact processes, this structure was not used to organize the taxonomy. This level of abstraction was not consistent among the informants. However, they had a clearer conceptualization of the strategies for health being related to physical health, mental health, or "overlapping," than they did with the characteristics, and this then was chosen as the organizing structure for this taxonomy.

Strategies for physical health were defined as those actions that maintain or improve the body's condition: "all those basic things that you do everyday to take care of yourself." "The basics" were referred to as: exercising, eating properly and getting enough sleep. These were seen as "the minimum for health" and the informants emphasized that the basics were not exhaustive.

Strategies for mental health were those aspects seen to enable one to feel worthwhile and in control of one's life, and thus were beneficial to an individual's mental well-being. The informants generally found it more difficult to explain strategies for mental health: "mental health seems harder to pin down than physical health." One informant said, "I thought that mental health took in everything that physical health didn't, but....it's the health that has to do with the mind...emotions...and in your perceptions."

Those strategies that overlapped between physical and mental health were seen by the informants to improve, protect, or maintain one's body *and* one's mind or mental well-being. Mental health was described as more important than physical health: "health is 90% mental and 10% physical," and ***mental health was also consistently explicated as being a precursor to physical health***. Strategies for mental health were all described as affecting physical health.

STRATEGIES FOR HEALTH				
PHYSICAL	Taking Care of Oneself	Keeping Fit		Playing sports
				Doing other physical exercise
				Doing physical activity regularly
				Exercising enough
		Eating Properly		Eating breakfast
				Eating healthy food
				Eating the right amounts
		Protecting	Avoiding Disease	Avoiding smoking
				Brushing teeth
				Dressing properly for the weather
PHYSICAL / MENTAL				Avoiding drugs
				Avoiding excess alcohol
				Avoiding pressure
				Keeping clean
				Getting enough sleep
	Goaltending	Having the Right Kinds of Goals		Having self-chosen goals
				Having health goals
				Having other kinds of goals
			Bal-anced	Having realistic goals
				Having challenging goals
				Working toward goals
				Achieving goals
	Coping	Relaxing		Having varied interests
				Having fun
				Taking breaks
				Compensating for disease or disability
		Managing Emotions		Controlling emotions
				Releasing emotions
				Accepting
				Understanding things
	Being in Relationships	Having Support		Having help from others
				Being encouraged by others
MENTAL				Being accepted by others
				Helping others
	Having Inner Strength			Thinking positively
		Being in control		Having self-direction
				Resisting negative influences
	Having self-respect			

Figure 4.3. The Taxonomy of the Strategies for Health.

Thus, "the basics" excluded major strategies for being or becoming healthy.

The remainder of this section is an overview of the perception and organization of the specific strategies for health as presented and verified by the primary informants, and as verified by the secondary informants. The three major categories of this domain (physical, mental and both physical and mental), are described in detail. How the strategies relate and differ to make up the categories and subcategories, as discovered in the d.r.s process is explained.

Taking Care of Oneself

The informants conceptualized some health strategies as behavior designed for "taking care of oneself." Some of these strategies were seen to impact one's physical well-being, and some were related to one's mental *and* physical well-being. Keeping fit, eating properly, and protecting oneself by avoiding disease were the categories of strategies subsumed under physical. The following paragraphs explain these physical health strategies in detail, *as conceptualized by the informants as a group.*

Keeping Fit. Within the physical category, keeping fit was the first group of behaviors described. The major strategies for keeping fit related to playing sports and participating in other physical activities; "even shovelling the walk helps." Regular and adequate physical activity were seen as important means for keeping fit. Keeping fit was one of the first group of strategies suggested by *every* informant; these were the strategies that were seen to have the most convincing benefits for health.

The athletic informants discussed how exercise or physical activity related to energy; energy was consumed in the process of exercise, and emotions and stress were released. Exercise for them was a way to control the physical body; one informant said, "I had a fever....and I swam anyway because the water was cool." The academic informants used a wide range of terms in describing the physical health benefits of activity, but basically their view can be summarized with the statement that "exercise yields stamina." Thus, athletic informants saw exercise as a way of *consuming* energy, while the academic informants saw exercise as a tool for developing stamina in order to accomplish things and cope with the physical demands of living.

Some informants in both groups presented the benefits of exercise in the prevention of heart disease. Also, both groups described how to properly begin exercising; that is, how to start off easy and gradually build to more difficult exercise. The informants all thought that much exercise was necessary to be healthy.

> I love to ski and the way I ski -- competitively -- is a lot of exercise. Even at the [weight room] I think, you know, more... how much I perspire...if I'm worn out at the end of workout, I think, you know, God, that was good exercise....So yes, exercise to me is a big factor of being healthy.

> I feel so much more revived because I'm doing more activity.

> Like, if there is a physical activity that you enjoy, well, you'll want to do it more.

The *principle of subjectivity*, described earlier in this chapter, was applied to exercise; however there was an *implicit* message that regular, challenging exercising was better.

> Going for a walk is a lot of exercise for some people.

> Some people say I exercise too much, but I don't think I do.

> I mean, too many exercises can be the person's own interpretation - "Oh, do I have to do this? 25 push-ups!," or it can be a person dragging themselves (sic) too far and becoming overworked.

> I think it has been proven that people who are healthy live longer. I mean, people who don't overdo things like...you have this goal inside to be healthy and maintain your health and not going to extremes like jogging 50 miles a week or something, I know some people who do that, but I don't think I could do that.

All but one informant (an avid swimmer) stated that too much exercise was not good. Exercising for health was placed as a variable in *Rusty's Triangle* by these informants.

Most informants emphasized that physical activity should be enjoyable to be healthy: "You find something you really enjoy -- I think of it as going out there and getting a good rush." One informant put it this way, "I didn't like running because all I felt like I was doing was getting healthy."

Reasons for being physically active were primarily for the purpose of avoiding being "fat," and taking care of your body.

> I get Seventeen magazine and that, and they stress -- or they'll just say something like, you know, "diet: you must eat right and you must...workout -- you can't just expect to lose it."

> [So your health is important to you?] Very. [Why would that be?] Well, I really hate the idea of -- being honest -- being fat and things like that. I really want to keep myself in shape so later on I'm not in the mess that...other people are in.

Two male informants, one from each subgroup, also mentioned the idea that being in shape with advancing age was desirable, and therefore exercising now was important. All of the informants were involved in organized physical activity, and working out was seen as beneficial to their health, but for the athletic informants, their health was seen as critical for their sport.

Eating Properly. The next sub-category under taking care of oneself was another strategy that occupied much "airtime:" eating properly. Details of *how* to eat properly were loosely explained; the referents were phrases like, "eat right," "eat properly," or a "good diet." Three main points were evident: eating breakfast, eating healthy food, and eating the right amount of food. One informant talked about eating regularly, not only daily breakfast, and the others only referred to breakfast as being important to maintain health. "If I haven't had breakfast I am not in top form that day."

Eating healthy food was discussed mainly in negative terms; discussion centered around avoiding junk food and sugar. One informant said, "junk food is not good for you, even though I hate to admit it!" Examples of other informants' comments are given here:

> Dieting -- I need dieting, I really do, to put myself back on track if I've been, you know, if I haven't lived up to my expectations or if I've gone over the acceptable amount of junk food....I don't do those, you know, trend diets, fad diets.

> I don't have a lot of sugary things.
>
> I drink a lot of pop and that's not healthy.
>
> We stop at 7-11, we get slurpies and stuff - I guess that's not too healthy.
>
> At home, my mom makes pretty healthy stuff.

The informants could not agree on which foods were junk food and which were considered healthy food. Most of them referred to the four food groups but did not volunteer details. When asked about the details, it was reiterated that as long as junk food was not ingested in excess, the diet was "probably healthy." Only one informant offered information about excess salt and two informants mentioned cholesterol as a potential health problem from one's diet.

The topic of junk food was much more of an issue for the athletic informants. They frequently presented phrases that implied a concern with the quality of the food that they ate. Also, in contrast to the academic group, the athletic informants expressed more concern about getting enough food; the academic informants tended to emphasize the importance of avoiding an excess intake of food. Because the athletic individuals were working out every day in "training," they probably required more food. Therefore, the right quantity of food was distinguished as important for health by all of the informants; however, ***the informants believed that the amount was subjectively determined.***

> If you diet too much, obviously your life expectancy is going to go down, if you lose too much weight you're going to become anorexic or have an ulcer or whatever.
>
> So, not going overboard. And the same thing as not eating too little, but eating just right.
>
> You have to make sure you get enough food and fluid.

It was surprising that the informants had few details about how to eat properly given that eating was considered one of "the basics" and that most of the adolescents stated that they had learned about eating in school. Nevertheless, their assertions about eating were stated confidently. There was a preoccupation with eating and weight that some informants explicitly acknowledged. The impact of the "thin is in" mindset in society was reflected, in an implicit way, by all the adolescents' comments.

Protecting. The next major category related to taking care of oneself has been called "protecting" because of the idea expressed that one must avoid bad things for self-preservation. The athletic informants presented the strategies in the protecting category with much more righteousness and "feeling." Within this category there are two strategies that were preventative: brushing teeth and dressing properly for the weather. These two actions, in addition to not smoking, were seen as strategies to avoid diseases. Other avoiding behaviors were seen as protective to physical *and* mental health. The final protective strategy identified by these informants was to keep clean.

Protecting the body in terms of safety was noticably absent and when asked about it, informants responded as though *severe* risk taking would be unhealthy, but they did not consciously link health with safety.

> Health and safety are just not the same thing.
>
> I probably wouldn't think of it (wearing seatbelts), but when you think about it that's an important thing. I think anyone that regards themself as important wears a seatbelt the same as I think anyone that cares for their body doesn't smoke and drink to the excess and things like that.
>
> I think that safety and health are very different, and I wouldn't think of wearing a seatbelt for *health*, but I can see that it would be a way to protect your body. But you don't wear your seatbelt and say, "I want to protect my body," you wear it 'cause it's a good habit, like safety.
>
> Obviously you don't want to ski cliffs or jump off very high mountains, and stuff like that -- not saying like "So take out skiing out of your life", just use common sense, like instead of dashing down the hill when you're young...take your time on the curves, learn a new technique.

Avoiding disability was never mentioned as a means for health and no strategies were identified, other than the discussion about seatbelts which was initiated by the investigator.

The informants talked about wanting to avoid disease, but they could not articulate how to do this except in relation to diseases caused by smoking, poor dental habits and inadequate protection of the body against the elements. Smoking was the most clearly understood health risk, and considered the most harmful. The informants knew that smoking caused deadly disease, but they did not discuss the diseases nor the disease process. "Like I know drinking can kill someone, but smoking can do it a lot quicker." Smoking was never discussed as harmless.

One informant mentioned skin cancer from sunbathing as a potential risk but went on to say:

> Well, I suppose the reason why I [suntan] is because I've never encountered anyone around me that's had skin cancer, so I've never had anyone, like my aunt or something, come home with -- you know, to get chemotherapy. You hear so much about it but it's not around *me*....I've never run into anyone with it.

Avoiding disease as a strategy was discussed loosely by these informants. Their lack of personal life experience and awareness of human disease was revealed. This was evident because the first two of the three strategies identified, avoiding smoking and brushing one's teeth, are the most highly publicized preventative behaviors in public health, and the last strategy, dressing properly for the weather, is one that virtually *every* mother in our culture has emphasized to her children.

The nine adolescents in this study found the remaining protecting strategies to influence both physical *and* mental health. Avoiding drugs, excess alcohol, and pressure, and keeping clean were strategies that protected both aspects of health; these are discussed in the following paragraphs.

Drinking in small amounts was said to be virtually harmless by all the informants. Drugs were *mostly* referred to as harmful; two informants admitted to trying drugs once. Drugs were seen as having physical and mental health consequences: "Doing drugs is physical, but you're mentally baked." Drinking in excess and doing drugs were often discussed together, related to "partying:"

> Like they go to parties and they get drunk -- like totally smashed -- and they wind up doing drugs there and all that. I think, like, it just all around makes them, like -- drugs can -- like they cut down on like their thinking ability and how they react and all that. And it'll eventually just kill their brain cells off. So they become...oh, what's the word?...sort of out of it....Just gone from the earth.

The general idea about alcohol was represented by what this informant said: "it overall doesn't hurt you too much unless you really get loaded and fall down and hurt yourself." That is, alcohol itself was not the problem, it was what happens to the person when they have more than a minimum amount that was seen as the health concern. The harm from smoking was a long-term, serious consequence; the harm from drinking and drugs was seen as immediate as well as long-term, but generally as less serious.

Pressure was arbitrarily described as the result of too much stress. Avoiding pressure was important because it was seen to have physical and mental health consequences, and it was described as implying a lack of control in one's life.

> You have to give your mind and body a fair chance at being healthy by doing things blow by blow (and therefore not letting them pile up).

> I guess you call it mental health...is not to let things back up or be in such a way that you get mentally tired or mentally depressed...when that happens you get physically run down often, I find.

> I put "under pressure" into the negative aspect because I think you can worry, but you shouldn't be stressful all the time and under pressure is very nerve-racking for many people and it is not advantageous to health.

> I think everybody can take a bit of stress and everything. But I think...too much of it, it'd start to affect your health and bring it down.

The last quote and some of the other informants' words revealed the belief that stress had to be in *excess* to be a health problem. Once again, the curvilinear relationship of ***Rusty's Triangle*** appeared.

The final strategy within the protecting category was keeping clean. Washing was seen as an activity one should do every day to "remove the bacteria" and was seen to "increase your life expectancy." Some informants explained that keeping clean was related to avoiding disease, but they could not identify any in particular. In addition to the physical health benefits of keeping clean, some informants stated that mental health was influenced also. "Like if someone feels that they are clean...then their emotional well-being will be better." Athletic informants emphasized the impact of keeping clean on the body and physical health. Keeping clean was not included in "the basics" because none of the informants thought of it when asked to elaborate on the basics. When asked if keeping clean should be included, they would say "sure," but they admitted that they did not think of it as equally important to physical health as the other three strategies (avoiding drugs, excess alcohol, and pressure).

Getting Enough Sleep. The final behavior that was a way to take care of oneself was getting enough sleep. Informants' opinions about what was adequate sleep ranged from five to nine hours of sleep per night. One athletic informant jokingly said, "for me, twenty hours would probably be enough." The subgroups did not differ in their opinions of the amount, nor the importance of, sleep. Sleep was described by both groups as having mental and physical health consequences, although athletic informants emphasized the physical benefits and the academic informants emphasized the mental effects. The first two interview segments below were comments from two athletic informants, and the latter three were from academic informants:

> [So how do you think he (a famous athlete) looks after his body besides the training?] Well, I guess...he trains and he gets a lot of rest.

> Well, I guess I don't get sick as much as other people also because I keep, I'm stronger, not stronger, I'm more resistant to being sick because I sleep enough and eat the right foods and all my white blood cells are going.

> (To be healthy you must) get enough rest...the inner energy...I need energy; I sleep.

> If you've been staying up and getting three hours of sleep, after awhile you're going to be in rocky shape (mentally).

> I find I can get five (hours) and still function but I really don't like that 'cause you're not really yourself when you haven't gotten enough (sleep). [You feel differently?] Yep, you feel a little more automatic and you can still think fairly clearly and react but everything's sort of on automatic pilot.

The following quote reflects the consensus of both groups: sleep had both mental and physical effects.

> I mean even sleeping is physical...even though it's not really, you know, movement so much as that it's for your physical health as well as for your mental health as rest will make you more ready to handle what happens.

Not only was getting sleep important, but how much was relevant.

> Like if I got four hours sleep and didn't eat breakfast, I wouldn't be in top form that day.

> I have to get my daily dosage of sleep; that way I avoid headaches.

The informants believed that sleep was important for one's whole well-being.

Goaltending

A major theme regarding the means for health was *goaltending*. The informants all related the process of goaltending to the process of attaining health. The *whole process* of wanting to achieve something, actively working on it, and achieving it was seen to contribute to one's health. This process was seen as one of the most important means for attaining, maintaining, and improving health, and it appeared repeatedly throughout the discussions.

> Goals are a part of keeping interested. Otherwise you get really despondent and....that's a bad way to get, because you start not looking after yourself and ignoring what has to be faced. You just get tired and everything's too much effort and work.

"The need to, wanting to do it (have a goal)" was the first step. The desire was seen as a mental activity "because you can't do anything physical, you have to say that you want to do it before you can do it."

Kinds of Goals. Having the right kind of goals was important. Considerable discussion was focused on the nature of goals that would be best for facilitating health.

Specifically, one should have self-chosen goals, health goals, other goals not necessarily related to health, and challenging yet realistic goals.

Goals were most helpful to health if one chose them for him or herself: "a lot of times things are picked *for* us" (said disappointedly). Choosing your own goals also meant that they would be enjoyable goals. These quotes relate how these informants felt about having their own goals in relation to health:

> You have to set goals for yourself -- it's a *big* thing...they have to be the right goals for you.

> You *earned* your health and it's more enjoyable that way.

> If you achieve it (a goal) through your own, it gives you a greater sense of satisfaction.

> If I'm not happy with what I'm doing, well eventually I become disgusted with it and seek for a way out. Then [I] try to achieve back my mental health again.

Having "health goals" was described as necessary for attaining, maintaining and improving health. These were goals that related to eating properly, exercising, resting and relaxing, and maintaining a healthy attitude and outlook. For example, in discussing goals about eating properly, one informant said, "You have to decide what you're going to eat...it's involving your health." The informants' words implied that health required planning and thinking. Having goals not directly related to gaining health was also described as being helpful to attain and maintain health. One informant, referring to a trip he was planning said this:

> The desire to want to...go out and do these things whenever you want encourages health....So it contributes to health and makes it a lot easier to do what it is you want to better your health.

Other informants saw the connection this way:

> You have to try all different kinds of sports, I think -- or -- not even sports, just interests...to find out things you're good at.

> [What about *any* goals?] Yeah, the same thing...it's really going to boost your morale or whatever. And like when you (do), you work even harder next time.

> Health gets really stagnant. So maybe if you set goals for yourself, not even in your work but in your -- in something that you like to do, set goals, and then you win a competition for horse-riding or....some kind of goals, that you have something to work for, so you just don't keep existing dully from one day to the next.

Any goal was seen to indirectly influence one's health through one's esteem and by providing enjoyment and satisifaction.

In addition, the informants said that the goals should be *balanced* so that they are realistic but challenging: "Goals are sort of self-imposed stress." The following exerpts of interviews reveal the discussion regarding balancing goals, as well as the indirect way the informants related goals to health.

> Like, have realistic goals. I think (this) is important for health...not to go overboard on the goals....Try and stress moderation.

> I need all these (goals) in order to go through to better health...even worrying and stressful things, just so you can overcome them.

> I think in order to be healthy you have to have some drive making you want to do better, making you want to get better both mentally and physically.

> Like [an author] wrote...if you have unrealistic goals, you're going to get discouraged and dejected and it's going to seem like you can't achieve anything, so why really bother, why exert yourself? And if you have no goals, you don't get dejected but you don't exert yourself because you don't really feel there's any need to. So I guess it's important to have realistic goals that you set for yourself. I think you have to set them for yourself.

> Then if you set goals like really, really high and you don't achieve them you might think of yourself as a real loser and be really let down by it...you can always achieve past your goals.

The informants used phrases that directly linked health to goals, even though the process was actually described as more indirect, (as reflected in the last two quotes). Both groups of informants had much to say about the process of goaltending. The informants were more confident in relating it to health than some of the other strategies. Thus, *the process of* *goaltending was ranked as one of the most important strategies for health.*

Working Toward and Achieving Goals. The athletic informants saw the process of the physical activity of working toward goals as follows: "If you're working at something...it allows a release of emotions." The academic informants did not describe this. Other expressions of the impact of working on goals are presented here:

> Usually to reach a goal you have to work in several different areas to perfect that and to reach your goal.... That would be a major factor for me to meet emotional health.
>
> [Swimming] has given me a healthy body and mind...it has given me a lot of habits.
>
> For me, dancing was very healthy for me, so having that focus in my life and dedicating my life to dancing during that period was very beneficial for me...it improves your mental health; you develop strength and endurance....
>
> You're expressing something as you work toward something.

Goal achievement was also considered healthy, primarily for the mental health benefits, but the achievement of *health* goals was, of course, seen as beneficial to physical health also.

> It feels so good when you take that red marker and go: scritch!
>
> If I do well on something, I guess I think of health as something that is more than just physcial...then you (sic) can feel healthier as well....they're (sic) better for it, I think.
>
> [Achievement] gives someone a reason why someone would want to be healthy.
>
> Once you begin building up your emotional health by finding out there is something you can do...or achieving something through goals, you can start taking more of an interest in physical health.

In these informants' eyes, the process of goaltending was one strategy or means for attaining health, primarily because of the mental health benefits, but the physical health benefits as well.

Often the concept of goaltending for health was related to achievement-oriented comments about attaining perfection or "being the best that you can be." Many of these individuals stated that striving for perfection was a goal that they personally have. These adolescents often talked about perfection and health interchangeably. Optimal functioning was emphasized, at the expense of minimal status criteria and behaviors for health.

> I guess (health would) sort of be the perfect body....try to be as perfect as you can with your body.
>
> You sort of want to be the best that you can.
>
> People are working hard to be the best that they can. No one is totally perfect ever, but they should try.

However, health was seen by these adolescents as an ideal state that few people, if anyone could reach because of the limitations of human beings and the environment. "It's hard to imagine anybody ever being (laughs) completely healthy, [and] having it all together." One athletic informant saw himself as having a "perfect score" and this score was in the context of how fit he believed he was: "I think people would think that I am 'megahealthy' because I swim so much." Only one other informant saw the possibility of optimal health but she admitted that she could not think of anyone who had perfect health. These informants believed that there was always something that one can do to improve. One informant said, "I can find a fault in everyone."

> I've never met anyone who would be a ten...I think everyone would cheat a little bit 'cause I think that's human nature that's it's absolutely impossible to withold all temptation. I think you're bound to bow to something and that wouldn't make you a ten. I can see someone being a nine, but not a ten.
>
> Even an olympic gold medalist has a beer once in a while.

Another theme appeared in both groups' comments repeatedly: *to maintain one's health, one must continuously improve.* "Say you are a B in health and you just do the same amount of exercise, then you will slip down to a C because you're not improving." In other words, if one's health is x, then one must do x + 1 to stay at x in the future. Thus, health was maintained by striving to be the best human being that one can be. Non-challenging goals would not keep one *improving*, and do not contribute to health, nor attainment of perfection.

> You always have to like challenge yourself more and more. That's the way I think of it.
>
> Every person is trying to improve themselves to be the best they can be and I think working towards your health and your (inner) strength and then applying it to the greater community is very important in developing that, in being the best you can be, it is important in that way.

There were some informants who reflected a more moderate view:

> [Setting limits is unhealthy?] Yeah, you shouldn't set limits for yourself. It could hold you back...from doing the best that you can.
>
> I think that's what a lot of people don't have....kind of an image to look to or a model to look to, not necessarily the perfect impage, but people kind of sometimes get health crazy and they think of extremes and there kind of has to be a moderation that someone can look to. [So instead of having...these television and magazine role models..] That's right. [...have a more realistic role model?] Yeah.

"Applying yourself" to be the best you can and the process of working toward goals were both important.

In addition to the idea that one had to have a commitment to health and that health had to be actively sought there was an underlying tone that health goals, especially for improving health, required effort, work and struggle. The athletic informants spoke of commitment and used swimming goals as an analogous goal to the processes of gaining health; the academic informants emphasized the determination, will, and desire for living as important in health goals.

> You have to want to be healthy in order to become healthy.
>
> ....[B]ecause if you just say you're going to go out and get healthy you know, it's kind of hard to do. But if you set goals and -- like you start out with small goals and you can start to see the improvements and stuff, and it starts to, you want to do more and things like that.

> You have to set goals and tell yourself that you're going to do this and this and this to be healthy.

> Staying in good health is a lot harder than (learning a new skill).

> I think health is probably one of the hardest things to attain. You have to apply yourself and try and carry out all of the different aspects, you know, mentally and physically, nutritionally and all of that.

Health requires commitment and was seen to require effort and application. Also, being determined was discussed in relation to goaltending and coping, and it also reflected this theme that health involves work and commitment. Mental determination was relflected by this informant:

> [So it's (health) related to the opportunities available, or the...?] Yeah, it's related to the opportunities you make and the ones that are present for you. *Because nothing's going to come unless you work to make sure it happens* (emphasis added).

If the process of health is hard work, why do adolescents care about their health? Six reasons were explictly identified: longevity, quality of life and enjoyment, sense of mastery over self, appearance, avoidance of unpleasantness of disease, and that if one is healthy, then one can make a difference. One informant said: "if you have energy, then you can...make a contribution to the greater community as well."

The informants related goaltending to one's will to live, (including the reasons), and one's motivation for taking care of oneself. That is, an interactive process which seemed to start with the will to live was evident. *One's will to live preceded taking care of oneself, then taking care of oneself necessitated and facilitated goaltending. The process of goaltending and the resultant achievement gave one a reason to live which, in turn, encouraged the development of a conscious will to live.* And the process continued while the individual improved. Although most of time informants spoke of this health process as "hard," at other times they described it as effortless and fun.

In conclusion, having goals was seen to be a most important part of the process for health. Physical health goals were usually discussed first, but the informants all agreed that challenges and effort increased health and thus any type of goal was healthy. Athletic and academic informants tended to start explaining goals with examples about exercise and weight loss. However, athletic informants more often gave examples of goals that related to physical activity and achievement in those areas. Both groups acknowledged that other goals that do not necessarily relate to physical health had benefits for health. One informant said, "I would definitely say it is the *desire* that is the healthy part," and another said, "achieving your goals...gives you a real sense of completion or just a sense of achievement....and then it gives you enough energy to set another goal or shoot off in another direction." Goals were so much part of these adolescents' day-to-day lived experience that health and goaltending wer[illegible]extricably bound.

Coping

Being able to "handle things" well was seen by these informants as maintaining mental and physical health. Coping was seen to manifest health and be a way of promoting health and preventing illness. The identified strategies were not explicitly called coping by the informants but they related them to managing stress and "being an effective person." The analyses of the comments revealed seven main strategies that were viewed as coping strategies that maximized health: relaxing, compensating, managing emotions, resisting, accepting, understanding things, and having help from others (the latter is also under the category "having support").

Relaxing. The informants thought that relaxing was different from resting in that the intention was to divert oneself from important and demanding activities such as schoolwork or swimming. Three strategies were specifically identified: having varied interests, having fun, and taking breaks. Doing different activities was seen as a health benefit not only for the value of experiencing variety, but also for defending oneself against the experience of failure.

> I don't think it would be too healthy for one person to focus on one thing and rule

> his life by it because you are (sic) teetering on such a thin edge, you know, if you (sic) succeed in this one interest.

> Don't become obsessed with one thing, if you have a setback or faliure in it, you'd be devastated.

> I think a variety is what makes you healthy....the key to being a healthy person is variety.

> Flexibility to change. [How is that healthy?] Because you're not setting yourself to a rigid state where after a while it won't get fun.

The range of what was considered a diversion varied. The academic group tended to describe qualitatively different experiences such as reading versus backpacking in the mountains, and both groups discussed doing different sports instead of the same one. One avid swimmer said, "For me, varied interests would even be, instead of one stroke, I do several." In general, the academic informants had a more typical lay view of relaxation as a strategy for health.

Having fun was often mentioned when discussing how one handles all the pressures. How to have fun was broadly and subjectively perceived, but there was an emphasis on doing things with friends.

> [You went to a movie. Going out with your friends to a movie. Would that --] Would that still be healthy? Yes, because I think it gives you a time to relax, and it gives you time to sit back and have fun....So to be healthy, yes, especially emotionally ~~healthy.~~

> When you're taking your life too seriously, I honestly think some people take their life too seriously. I think you have to relax and look back and laugh at things. But, if a person loses their childhood, I mean like just loses the fun of just being a kid, sacrificing that for always looking toward the future and "What am I going to do in ten years time?"...(that person) is going to suffer from pressure, and you're (sic) going to be stressful and you're (sic) always going to be worrying.

Taking breaks referred specifically to short term relief from an activity, such as:

> Take a hot bath and read a book or something, just go out and lay down and go sleep in the sun or something.

> Just hanging around the house a lot, just doing something with other friends,

> something to keep our minds off swimming, so we don't face burnout.
>
> Going out with friends...it would be a good psychological break from something, because you do need a psychological break.

Only the athletic group (two individuals) referred to taking longer breaks; taking a day off a week or a month or more off each year from swimming to relax.

Compensating. Compensating as a way of coping was described as being related to health in direct reference to coping with a disease or disability. The consistent theme was that *if one had a physical health problem, then compensating would improve one's health.* Compensating was using physical or mental means to make up for physical or mental deficiencies. The most common example given were those in which both physical and mental strategies to compensate for a physical health problem were used.

> So if a person feels totally overthrown or mentally defeated by being restricted to a wheelchair all his life, or facing that prospect, then perhaps they (sic) won't struggle to be what they were (sic) before, like physically fit. That is one part of what you were before one (sic) got into a wheelchair, but if they (sic) have the will to fight and you know, be just as good as they (sic) were before or better, then I'm sure they (sic) can do it, they (sic) can be healthy in a wheelchair.
>
> [Asthma]'s something that you can't change so if you can like just say, "Oh well, so there's somethings that I can't do, that's alright with me" then you just find something else that you can do better then it counterreacts it and then you're healthy!
>
> In most cases, there's a way that you can go about fixing the problem, and then if you take it by the hand and go for it and try and get rid of it, then you're contributing to your own better health.

Managing Emotions. Having one's emotions under control was seen as positive. In addition to appearing healthier if one managed one's emotions, controlling *and* releasing emotions were seen as strategies that enhanced health and prevented mental and physical health problems.

> Releasing your emotions. Actually channelling that energy into sort of back into your body to work you harder and um...just feel good about it.
>
> I used to lose my temper all the time and then I guess I figured out it wasn't doing

> any good to lose my temper, I just kept calm and worked things out slowly, think about things I guess. Not too hard to control your temper and relax.

The athletic informants seemed more concerned with control and release of emotions than the academic informants. Athletic informants all discussed mental attitude in relation to performance in their sport, thus managing emotions was more of an issue because of their experiential bias.

It seemed that the informants saw mental strength and control as an "ideal." The informants were asked how one attained this and how possible they thought this was. Although they sounded confident in their responses, their descriptions of *how* were merely further description of the ideal. Their words implied a denial of the difficulty of being "in control:" "you have to handle all the things that come your way."

Accepting. Being able to accept things "that you cannot control" was mentioned by most of the informants in discussions about coping with diseases or dealing with a negative emotional situation. The idea presented was that one can "move on after failure" and get on with things instead of having it "drag you down mentally," which eventually influenced physical health as well. "Accepting something is one way to begin to overcome it."

Understanding Things. Various ideas surrounding understanding were presented. Some of the academic informants interpreted this as a certain level of intelligence (like a minimum) that was seen to be necessary for taking care of one's health and valuing health. For all of the informants, understanding things meant gaining insight about their problems that enabled them to cope with, or overcome them. The academic informants emphasized thinking *clearly*, (the quality of thinking), rather than just the presence or absence of intelligence. These exerpts reflect various ideas about intelligence that the informants as a group expressed:

> Maybe if you're intelligent, you have more desire to know yourself and what you should be doing to keep yourself healthy.

> Well, I guess that way in which [intelligence] would be related [to health] is just

> using your intelligence to be rational, I guess. Like to be able to think things through, like making good decisions and things like that. ....But I don't think of intelligence as in marks in school or *I.Q.* .... it doesn't seem quite right to put that in with mental health.

> Like intelligent, not to a point of being a genius or stupid, but just being able to think and reason, that's all.

> [Intelligence for health is] being able to think clearly and being able to respond to problems that arise.

> Intellig[illegible] is like a benefit [to health].

> Maybe intelligence makes you more concerned about some things because you're curious about them.

Distinct from *having* knowledege was the idea of knowing the *meaning* of something, and this was related to health as well.

> Just knowing yourself to some degree is important. Understanding why you do things...even if the only reason is to make sure you don't do wrong things again....Just being a little bit introspective.

> I feel healthy because I'm trying to understand things...I guess you could say it's with maturity.

The general idea was that knowledge that led to understanding promoted coping and facilitated one's well-being, be it for a physical health problem or a mental health issue.

Having Support. Another strategy for dealing with problems, or *coping*, was obtaining or having help from other people. Having help from others was seen as a coping strategy *as well as* beneficial to mental and physical health from the perspective of being in human relationships.

The informants did not identify health professionals as helpers, they identified experiences with family members, friends, and special activities such as workshops provided by various groups. The emphasis in this category leaned more toward the mental health benefits, although some of the examples used included physical health outcomes as well (such as weight loss).

The coping category reflected the level of understanding that these informants had regarding their emotions and the stuggle for emotional control and well-being. Their expectations seemed high for themselves and others; the investigator had a sense that they were talking about the ideal much of the time. The informants appeared to have less confidence about their knowledge and understanding of these strategies than other groups of strategies.

Being in Relationships

The next major category of strategies shares the last sub-category mentioned in the coping section, (having support), in addition to the strategies of helping others and being accepted by others.

Having support was described as having help and being encouraged by others. "Without [support] you think maybe you're wrong in trusting yourself." Direct help combined with encouragement was seen as facilitating mental well-being and attaining health-related goals.

> Like they'll help you with your interests, they'll help you develop them, they understand your goals. And they understand the limits you set and how you understand things.

> Sort of just like how people look at you, like, and your commitments. Just how they understand you, or your support you get [from them].

Supportive people were primarily one's family and friends, according to these adolescents.

Being Accepted By Others. The way that being accepted by others was described was more clear than the descripitons of other strategies within this category. One informant described a process where being accepted led one to be motivated to take care of oneself, which led to a more acceptable appearance and thus facilitated one's acceptance.

> Once you're accepted, it helps your mind and everything. But I think with your body, you know, like if you're accepted then you try to be -- like you want to be, so you make your body more attractive or whatever. That might sound kind of dumb, but.... [No. If you are accepted, then you're motivated to look after yourself, so it works both ways?] Like a circle kind of, yeah.

This process was also reflected by other informants. Another informant said this about acceptance: "It's psychologically healthy to know that you're accepted with friends -- that they want to spend time with you so you're accepted." This strategy had more importance to the athletic informants. They seemed to have an idea that interdependence was related to one's well-being; they gave more examples about supportive relationships than the academic informants.

Being accepted by others, along with helping others, were seen primarily to relate to mental health attainment.

> Like if you help someone to like carry out their ideas or interests, when you want to do something, they'll help you back. So it sort of influences whether or not you should help them or not, because in turn they'll do the same thing.

> I think you'd have to be about a five, you'd have to be half way there yourself, and then as you helped this person you'd gain it because you'd feel better, your mental health.

The final two strategies, having inner strength and having self-respect, were identified as ways to attain, maintain, and improve mental health. Having inner strength was referred to as a specific strategy, but most informants placed the three behaviors described below, within "inner strength" as a broader category as well. This formation was adopted for the taxonomy by preference of the investigator.

Having Inner Strength

These strategies for health were one's resources that came from within. The strategies that were described as fostering inner strength were: "thinking positively" and "being in control" which included the means of having self-direction and "resisting negative influences." Inner strength was described as the motivating force from the person, the drive that was behind health. The strategies that related to inner strength were seen as the most important in bringing someone above and beyond a basic state of health.

Thinking Positively. A positive outlook was spontaneously described by most informants as a powerful strategy to attain and maintain mental health. Most of these adolescents mentioned it without being prompted by the cards.

> You have to have a positive frame of mind about yourself, you have to like yourself, and you have to do things for yourself.

> It has to be a genuine, positive reaction towards your circumstances and the situation you are in.

> I think health is basically decided by your attitude on life.

The informants were not able to describe how a positive outlook directly influenced health, but they were confident in their assertions about its effect on improving health.

Being in Control. This strategy encompassed having self-direction and resisting negative influences. Having self-direction, defined as being in control of decisions and doing the things that one wants to do, was a strong theme. It was one aspect of self-choosing one's goals, but it was seen more broadly as an experience of being in control of most things in one's life.

The issue of control in relation to health had two perspectives. First, control was very important to these middle to older adolescents in terms of the *quality* of their lives. Although not explicitly stated, these informants revealed the belief that having control was vital for their health and survival, especially in relation to their mental health.

The other aspect of control was the implication by these individuals that their health is "basically in [their] hands." All informants expressed the idea that some health problems are outside of individual control, but *most* things that affect health are within a person's control. Only one informant (athletic) described health as totally directed from within: "I think illness is basically in your head, if you want to get sick, you will. I won't let anything get in my way, and I just don't get sick."

Some informants described how control related to health and how health may be lowered from having a lack of self-direction:

> (Not deciding for yourself) could cause you to have the lack of...you're not willing to try anything, or else you're under a lot of pressure from friends.
>
> [A lack of self-direction can] stop you from doing stuff to maintain your health.
>
> Do it on your own -- you're more independent which gives you a greater feeling.
>
> You have to have that inner strength, that drive and desire to have be able to want something and when you just have to use those abilities to make the decisions that are going to affect you and you'll hopefully make the right ones.

Self-direction, together with an ability to withstand negative influences, comprised the strategy of being in control. The informants discussed resisting influences that would be harmful to the body, as well as resisting peer pressure that might threaten one's self-direction and self-esteem. Most of the discussion centered around being strong enough inside and liking oneself enough, to not behave in such a way that one's physical and mental well-being were threatened.

> You have to be able to develop the strength as your own individual in order not to be influenced by all these negative aspects.
>
> (In order to build health) you have to detach yourself from (friends and the media) and be your own individual.
>
> With being at the age I am, I can tell you -- I'm sure everyone can tell you. It's a difficult time because you're being influenced by a lot of outside things, and a lot of people are susceptible to that. Unless, if they were *experimenting* with things, I can see that....but people who do it on a regular basis are harming themselves. They have to realize that some things they don't do (sic) aren't right.
>
> If they (friends) pressure you into something that you don't want to do, it bears on your mental health. Like you're having this fight with your conscious...if you should do this or not.

All of the informants acknowledged that their peers influenced them but they were also quick to point out that their peers usually had a positive influence on their health:

> People in the...club...they're more of a good influence and then people that aren't...can go either way....I think peer pressure is overrated.
>
> [What is it in people that moves them up (the scale) or makes them be up there?] It would be some peer influence, but I think it's mainly a person's decision and a person's immunity to being swayed by other people.

Thus, the negative influence was not peer pressure per se, but anything harmful to the mind and/or body.

Exploring Influences. The informants spontaneously discussed peer and other influences on their health; they believed that health was *mostly* within their control. Questions were asked with the purpose of being able to describe those factors that the informants thought influenced their health status and health perceptions (and in what way -- negatively or positively), as well as to identify their perceived *control* over these influences. In the card sorts the informants categorized the influences that they described into three groups: having much control over (called "choice"), some control, or little control. These results are presented in Table 4.2. The investigator grouped the influences into "internal," "external," or both because the adolescents saw these influences as being internal or external to *their sphere of control over the influence*. The internal factors were perceived to have the most impact because the informants had the most choice about, or control over, them.

In general, these informants had a broad view of factors which influenced their health or health perceptions. They were open about how the factors influenced them personally. They stated that their *awareness* of these factors' influences did not necessarily decrease the influences' effect on their behavior.

These quotes are samples of the discussion about factors which influenced health:

> I think health is really a person's own concern (questioning tone). Well, I guess when you're little (it's) your parents...I remember my parents standing over me while I brushed my teeth and things like that, but after you get to be...well certainly by this age it's mostly your own concern and if you don't wnat to do anything to keep yourself healthy, then you won't be healthy.
>
> I guess it depends a lot on what your ideas are and what your family's ideas are -- how you think.

Table 4.2: Factors Influencing Health Status and Health Perceptions

FACTOR	IMPACT	
	Positive	*Negative*
Internal Factors (much choice)		
-Inner Strength	●	
-Self Respect	●	
-Knowledge	●	
Internal/External Factors (some choice)		
-Friends	●	●
-Being Ill or Disabled	●	●
-Models/Athletes	●	●
-Audio/Video/Print Media	●	●
-Professionals teachers/coaches psychologists doctors	●	
External Factors (little choice)		
-Family parents siblings	●	●
-School	●	
-Health and Disability or Illness in Others	●	
-Support From Others	●	●
-What Others Think of You	●	●

> ...and I've been raised, "you have to look good."

> ...say you see this star or something in the paper, athletic star, and you say, "hey, is this" -- like this is an influence, like -- "maybe I can be like him or her." So I guess reading about people, like -- or just any article influences (sic) on what you're going to do.

> If you really feel good about yourself then I would think that you would want to keep yourself looking fairly well...and everyone wants to be (like) a model. [Is that so?] Yeah, they see models as the ideal people physically.

The two influences that were the least influential were those in the classroom and encounters with health professionals.

> ...if you go to the doctor at school, they're always giving you pamphlets on how to do things like keep your body going, why not to smoke, why not to drink...what pills not to take. And the doctor's always telling you what not to do and what to do and everything. (pause) But I don't think that really -- like, most of the...pamphlets you get at school about health are a pile of garbage, or else people know most of the stuff already. [You know it already.] Yeah.

Although not mentioned and discussed as often as some other influences, and although no in the category of the most control, the influence of the family was given *more weight* than other influences. The influences that were seen as most important were one's self, one's family and friends, being ill or knowing others who are ill, and the media.

Having Self-Respect

The final strategy was having self-respect. The informants said that self-respect could be developed, people gained self-respect partly by the response of those around them. It was difficult for the informants to state *how* self-respect was developed; some struggling was evident in their words. For example, when asked to explain *how* one develops self-respect, an informant sometimes would begin a discussion about what self-respect *was*. For example, an informant would say, "*Oh yeah*, you can do many things to develop self-respect! [Like what?] Oh, it starts when you're little, and it just develops -- it has to do with maturity" (emphasis added). The confidence in the non-verbal aspect of the response was cancelled by the inability to articulate actual strategies. If the investigator probed for more explanation, an informant would look puzzled and say that he or she wasn't really sure. The individual elaborated to a point and then say that he or she felt frustrated and that he or she were unable to explain what they *really* had in mind. Of the strategies that were offered, they were similar to some of the other strategies mentioned. In this way, self-respect was related to other strategies, but because it was emphasized as being important for developing health, even though specific actions were not articulated, it was kept as a distinct strategy.

Having self-respect was seen to impact all other strategies: taking care, goaltending, coping, being in relationships and having inner strength. "You have to be able to develop the self-respect, caring for yourself, before you can start doing anything else. *It is the basis from which a person grows*" (emphasis added). All of these processes had an impact on the development of self-respect, especially the process of goaltending. "You have to have a positive f~~rame of mind about your self.~~ You have to like yourself, and you have to do things for yourself."

In summary, the adolescents had more difficulty discussing the mental health strategies and they were sometimes presented implicitly. The following exerpts are quotes which were helpful in determining these informants' views about mental health strategies.

> [And other people in wheelchairs (besides Rick Hansen)?] Oh, yeah, like even though they can't use their arms or legs they still have the mental side....You don't have to be physically active to be healthy. As long as you are in a happy state of mind, then the body will take care of itself, obviously, it has to be a genuine, positive reaction towards your circumstances and the situation you are in.
>
> Do it on your own, you're more independent which gives you a greater feeling.
>
> You have to believe in yourself, you know, sort of be proud of yourself to be able to do something...to become healthy.

The importance of the mental health strategies was frequently emphasized during the discussions about "ways to health." Inner strength, together with self-respect, were seen as the basis from which health was derived. This was the closest the informants came to the idea that health could be generated; their comments implied that they thought the main source of health was within.

Summary of Results

An emic view of conceptualizations of health were organized around the structure and contrast of related ideas. *The Taxonomy of the Characteristics of Health* and the *Taxonomy of Strategies for Health* were presented as a way of organizing the copious phrases and ideas that the nine primary and two secondary informants in this study keenly shared with the investigator. In addition, *cultural themes* that were evident were discussed as they arose in the text. Some of the themes clearly reflect these individual's lifestyles within their subcultural groups since they were selected from achievement-oriented and health-conscious groups (athletic and academics). The informants shared their experiences and ideas about health, and developed their viewpoints during the interviews. This chapter presented the results of the study as a "translation" or interpretation of what these informants said about health.

The following text is for the purpose of critiquing these results and discussing the findings so that they are of optimal value to scholars. In addition, the ensuing final chapter will include suggested implictions of the findings for nurses and others who work in health promotion with adolescents, as well as suggested areas for further study based on these results.

V. DISCUSSION

This study was designed to elicit adolescents' emic view of health. The discussion which follows will review the methods and findings of this study for their merit and utility. The adolescents' view of health will be deliberated first emphasizing three areas: the concept of health, including the comparison of the subgroups, the influence of health status perceptions, and other literature about the concept of health. This is followed with a discussion of the methods used and the limitations of the study. The implications for nursing practice, including adolescent health education, and the recommendations for further research will follow.

An Adolescent View of Health

Health was conceptualized by these adolescents as an experience, a value, an end, or as a means to "goaltend." They stated that health was an experience that often escaped awareness except when ill, or when a conscious effort was made to notice health. The idea that health is an experience primarily known through its antithesis is not unique to the adolescent population. This phenomenon has been deduced and described by many scholars writing about perceptions and experiences of health, (for examples, see Cardus, 1973; Dubos, 1978; Frankl, 1967; Kottow, 1980; Payne, 1986; and Tripp-Reimer, 1984). The informants in this study explained that having an illness was not the *only* way that they came to know the experience of health; other factors were listed in the results chapter and are discussed later. Most often, adolescents had the perspective that health was manifested in someone by their appearance and behavior and that there was a process to be and become healthy.

Bruhn's, et al (1977) nine developmental tasks for the process of attaining minimal wellness for adolescents listed in the literature review (p. 11) are examined in light of these results. Two of the nine tasks deduced by these scholars were not discussed at all by the informants in this study: "learning economic responsiblity" and "learning the importance of time to self and the world" (Bruhn, et al., 1977, p. 216). There are four tasks associated with being in relationships and the data from this study reflected agreement with the four tasks: "learning social responsibility for self and others;" "experiencing social, emotional and ethical commitments to others...;" "reconciling discrepencies between personal health concepts and observed health behaviors of others" (principle of subjectivity); and "experiencing degrees of structure or flexibility in social institution and interpersonal relationships" (Bruhn, et al., 1977, p. 216). The final two tasks were clearly perceived and emphasized by these adolescents: "learning to cope with life events and problems" and "consideration of life goals and career plans and acquiring the necessary skills to reach the goals" (Bruhn, et al., 1977, p. 216). However, in the latter task the authors refer to *life* goals and *career plans* and these informants emphasized that more immediate goals were related to health.

Characteristics of Health

Most of the informants emphasized that *appearance* was the main indicator of health, yet there were suggestions of embarrassment about their bodies. The emphasis on appearance as an attribute of health was reflected by adolescent peer groups in a Minnesota study lead by Hedin, Wolfe and Arneson (1977) about health perceptions. The attributes of energy, body tone and disposition were similarly described by the Minnesota adolescents when compared to the adolescents in this study. The Minnesota study was implemented more than ten years ago and semistructured interviews with peer groups were used. The researchers did not provide details about the sample so it is difficult to interpret any specific differences or similarities with these findings. Because of group dynamics and the peer group influence their data may be less valid than those of the current study.

A recently published "focused ethnography of teen health" with adolescents thirteen to eighteen years-of-age in Colorado also reported an emphasis on appearance, and some other similarities with these findings are evident:

> When asked directly, many stated, health means "looking trim and feeling good." Some related health to exercise and eating right. In addition, being healthy meant not being tired, not being lazy, not feeling 'rotten.' Good health was associated

> with athletics by many teens....Some mentioned mental health issues such as being happy, feeling moody, or setting goals (Magilvy, et al., 1987, p. 39-40).

These perspectives were *not* evident in the descriptions of health given by senior adults in a grounded theory study by Thorne, Griffin, and Adlersberg (1986). This is likely because adolescence is a period in which one's identity is in formulation and being "caught up" in one's own appearance and performance can be seen as evidence of a developing identity. Thus, *these adolescents' ideas of health reflected their developmental stage.*

Many of the criteria of health are lifestyle-related such as the characteristics that appear under appearance and energy, but the informants related the characteristics to appearance rather than lifestyle. The word "lifestyle" rarely came up in the informants' comments.

Strategies for Health

Regarding strategies for health, Brunswick's (1969) study of 122 twelve to seventeen year-olds' perspectives of health yielded a list of five behaviors that were good for health: getting enough exercise, eating the right kind and amount of food and eating regularly, avoiding smoking, getting enough sleep, and avoiding too many sweets. The validity of this study cannot be ascertained because the method was not reported, but these strategies' similarities are striking if compared with the strategies identified by the two subcultural groups of adolescents in this study. The adolescents in Brunswick's study and the nine informants in this study are *almost twenty years apart in time* and they could, therefore, be two separate generations! Perhaps *improving* awareness of a basic healthy lifestyle has not been necessary for the adolescent population for a long time.

The adolescents in the Colorado study referred to goals as a strategy for health. The topic also appeared in the results of the Minnesota study. The cover terms used in the Minnestoa study differed; for example, the report used the term "normalcy" to reflect being able to carry out tasks and goals. The academic and athletic informants in *this* study, as discussed later, emphasized that doing *more* than the normal manifested more health, whereas this was not evident in the reported results of the Minnesota group.

The Diffferences Between the Athletic and Academic Informants

Despite the cross-over of the individuals in these subcultural groups selected for this study, there were some distinctions in their conceptualization of health that merit discussion. Generally, the academic informants' interviews provided quality data for this study; they were more articulate than the athletic informants. However, the athletic informants seemed more genuinely keen to be involved in the discussions. Both groups were equally verbose. The following paragraphs discuss differences between the athletic and academic informants specific to their perspectives of health.

Differences between the academic and athletic informant groups were noted in many of the taxonomic categories. Generally, one difference was that the athletic informants presented a physical health bias and the academic informants incorporated a mental health slant. These biases were reflected especially in descriptions of the attributes of endurance, having energy, avoiding burnout, being clean, all the aspects of showing concern, and the strategies of exercising, relaxing, sleeping, and as mentioned, goaltending.

The academic informants discussed mental health more than the athletic informants; however, both groups *started* by describing health in terms of its physical constituent. One *academic* informant strongly equated health with fitness and physical activity until prompted, almosted urged, by the interviewer to explain more about health. The emphasis given to physical health by the academic informants surprised the investigator. However, since two of the four of them were seriously involved in athletic activities, the lack of a difference might not truly represent the differences in these subcultural groups.

The informants generally saw perfect health as unattainable. However, one athletic informant scored himself as a ten because of his perceived fitness level, but unique to this informant, health was seen as a means to fitness. The discussion related to this will be presented with the theme about aiming toward perfection.

An area that had general agreement was related to goaltending but the examples given when discussing this component varied. Not surprisingly, the athletic informants usually gave physical health goals as examples. The academic informants also gave physical health goals but incorporated other examples of health-related goals and other goals, such as learning, or travelling. Both groups agreed that all goals were related to the development of health.

One difference was that the athletic informants in this study reflected a stronger sense of social involvement. Being accepted by others was emphasized as more important to their health, and managing emotions was more of an issue. Also, illness, nutrition, rest and emotional control were more emphatically presented by the athletic group. For example, avoiding junk food and burnout were presented as real *concerns*. It was evident that the athletic informants held these points as *issues*, and the academic informants, as a group, had few ideas that were presented as issues.

As described in Payne's (1986) phenomenology, the experience of health was associated with forgetting about one's body. She says a sense of unity was present, and interrelatedness about the world is present in the experience of health (Payne, 1986). Thus, the emphasis on physical health and the body by the athletic informants may have been because of the importance of body functioning to the performance in their sport, and the sense of social involvement may reflect a higher level of health experience in the athletes.

The academic informants' perspective revealed a *process* orientation to health; health was part of living. On the other hand, managing oneself to promote health as a *goal* or a means to an end was reflected in some of the athletic viewpoints forwarded. Once again the discussion surrounding goals is a good example of this difference. The academic informants thought of goals as reflecting and influencing one's will to live; the athletic informants focused on the motivational aspects and what would be the *results* of the goals.

The academic informants had more realistic and "typical" ideas about illness. Illness was something to conquer for the athletic informants; it was something to succumb to for the academics. Once again, the atheltic informants felt a stronger sense of control over their world as evidenced in their more environmentally interrelated perspective.

That is, the desire to be in control of the body was more evident in the athletic informants' comments. The academic informants wanted to master the internal, or mental, aspects. They emphasized the need to understand things more than the athletic informants *and* related the ability to understand mainly to mental operations rather than knowledge about physical health. The experience of health seemed more internal to the academic informants.

In summary, there were enough differences between the academic and athletic informants that one could hypothesize, *despite* the cross-over, that the subcultural group that an adolescent is in affects his or her concept of health. However, these comments must be kept in perspective; there were far more similarities than differences and the degree of differences, as well as to what degree the cross-over of groups has influenced the differences and similarities, are not known.

Cultural Themes of Health in Adolescence

Themes are defined by Spradley (1979) as "any cognitive principle, tacit or explicit, recurrent in a number of domains and serving as a relationship among subsystems of cultural meaning" (p. 186). In this study several themes, (italicized in the text), emerged during the analyses, and the themes are discussed in terms of the developmental and cognitive characteristics of adolescence. Some themes are compared to ideas identified from other related studies.

The first and most consistent finding was the importance of *goaltending* in promoting health; that is, having, working toward, and achieving goals. There was agreement that goaltending was very important because of the esteem and skills one gained in the process. Both the athletic informants, (all competitive swimmers), and the academic informants, (aiming for the Honor Roll in school), had many goals and were competing at very high levels. Doing their best at all times to achieve perfection or honor in certain areas of their life were very real objectives for these individuals. The aim of being the best that one can be was seen as an ideal that applied to "everyone."

Closely related to achievement was the frequently expressed idea that *one should aim toward perfection*, including perfect health. For these young adults, while perfection is the goal, *most* of the informants acknowledged that perfect health is probably not attainable. *If* an adolescent believed that perfection *was* the goal, and perfect health was not attainable because of a chronic illness or disability, serious mental health consequences could arise. These adolescents saw themselves as relatively healthy and they acknowledged perfection as an ideal, and they displayed no evidence of mental health problems. The *Canada Health Knowledge Survey* (1984) report stated that highly active grade ten students, (modal age of fifteen years), scored lower on items related to depression; the adolescents in the current study reflected feelings of high esteem and confidence. *Near* perfection for health was attainable in their eyes, especially for the athletic informants.

The emphasis on goals may have been an artifact of having had high achievers in the subgroups. However, the senior adults that discussed health with Thorne, Griffin and Adlersberg (1986) presented a similar view that was labelled by the investigators as "competence," and was described as productivity. The Colorado adolescents associated health with setting goals. The emphasis that the nine informants in this study had on goaltending may *not* be related to their subgroup orientation; planning, doing and accomplishing to improve may be an integral part of human health experience and thus personal health promotion. The idea that health is a function of producing or achieving is a consistent finding in studies of lay perceptions. The degree of importance, or its focus and emphasis, appears to differ between age groups and subcultures (Bauman, 1961; Hoke, 1968; Morse, 1987; Natapoff, 1978; Robinson, 1986).

Health was seen as all-encompassing: "Everything I do relates to health." Whenever informants were asked "Does 'this' relate to health?" they almost always said that the idea was related to health in *some* way. There was often an inability to articualte *how* an action related to health; these instances reflected of a lack of ability to recount some abstract ideas verbally. There were times that informants saw no *clear* relationship between health and an item, for example, going out with friends, and in these cases they said they had a "sense" that they were related. Many of the specific characteristics or strategies were not included in the taxonomies because the informants could not, with some degree of clarity, describe how they were interrelated. The taxonomies do not represent the idea that health included everything; they are not meant to be representative of one's *experience* of health but of the structure of the entity.

Health was stated to be "very important" to these informants. However, in the Colorado study of adolescent views of health, health was not ranked as first or second in importance as a *concern* (Magilvy, et al., 1987). These nine informants indicated that they sometimes took health for granted and so at times it really did not seem important to them. The apparent contradiction with regard to importance was not seen as such by these adolescents; they thought that, generally speaking, when one had health, although it was important, it was not a major concern, because it was not absent.

Health was explicitly stated as something one has without conscious effort, especially for young people, and yet ***the informants implicitly indicated that developing health required goal-setting, working at it, and much effort and commitment***. It may be for these individuals that a healthy lifestyle had been adopted so gradually and was so much part of their day to day living that they were infrequently aware of the effort involved in promoting health. Some of the informants expressed the idea that continually improving health as one gets older would be more difficult, and they were anticipating that more effort would be required for health as they age. The *dominant* part of these explicit and implicit comments was that promoting health was mostly an effortless endeavor and that generally health was taken for granted, even though it was "important." A study of Minnesota adolescents' health by Hedin, Wolfe and Arneson (1977) described a similar "contradiction."

The adolescents generally spoke of an experience of imperviousness or of being low risk for health hazards; the exceptions were smoking, doing drugs, being overweight, contacting minor illnesses, and "burning out." All of these hazards were present and evident in their day to day lived experience; they could provide many examples. The informants all claimed to take action to avoid the ensuing physical and mental problems from these hazards. Other hazards that were overlooked, such as environmental or safety hazards, or risks related to other chronic diseases and lifestyle diseases (other than with smoking), were not in adolescents' frame of reference. This may have been because the consequences of these hazards do not occur with any frequency in an adolescent's life. In addition, these adolescents were selected as healthy individuals, and have had little life experience in comparison to adults. Thus, their few experiences with physical breakdown limits their basic knowledge about the possibility of illness. They assume that most things will not happen to them; the improbable is just that -- "improbable." They implied that if the risk was not self evident, then it was unlikely that they would adjust their behavior. As presented later, one's "exposure" to illness experiences was seen to be an important influence on one's concept of health.

These observations about perceptions of risk and of the lack of awareness of safety, environmental concerns, and chronic diseases are consistent with the findings of the Colorado ethnography of teen health (Magilvy, et al., 1987) and the *Canada Health Knowledge Survey* (1984). In the Colorado and Minnesota study and this study pregnancy, sexually transmitted diseases, suicide and accidents were rarely mentioned spontaneously; however, the Minnesota and Colorado groups obtained data about these areas because they used some structured questions. Some authors have claimed to observe the self-perceived "invincibility" of adolescents, but the studies that relate to adolescent health have not reported nor explored this concept in relation to health status and control (Elkind, 1974; Kovan, 1979; Sternlieb & Munhan, 1972). Studies about adolescents' experiences of *illness* have begun to explore these issues and their relationship to each other (Blum, 1982).

Another theme, called the *principle of subjectivity*, appeared frequently in discussions about ranking the adolescent's own and others' health. That is, *an individual's personal circumstances and perspective were considered when judging health status*. Also, it was implied that one cannot and should not judge others. These individuals were influenced by how others view them, therefore this theme may have been a result of a developmental consideration rather than a reflection of the adolescents' true viewpoint about health and its characteristics. The senior adults in Thorne's, et al (1986) study also considered the subjective point of view in describing their and others' health so this may be a theme that is consistent with people's perceptions of health throughout their lifespan. This context of health may facilitate experiencing health through the life process.

With the idea of subjectivity, a contradiction was present. In contrast to individual consideration in judging and rating health, these adolescents implicitly presented an egocentric belief that their subjective point of view was best. The informants implied that they thought their view of health was likely to be more inclusive and accurate than others' views. Some informants openly put down and criticized individuals who had what they thought of as poor health. Other informants praised those who did what they thought was important: "I rated her high because she swims, and anyone who swims is good in my books." Most of the informants said that they were sure *other* adolescents did not think about mental health as an important aspect of health, but *they* had this awareness. In general there was a minor struggle to incorporate other viewpoints against a "pull" of wanting to feel knowledgeable.

The perception that other adolescents would not have as clear or as broad of a view of the concept of health as oneself probably reflects *an absence of discussion of health among adolescent peer groups*. This perception was probably also related to the norm of masking one's concern about oneself. It was "OK" to talk about diet and exercise and body build, but not about wanting to be or become healthy, or what health means or feels like. It was noted that the discussions about health between adolescents was limited by the language that they used. In the Minnesota study peer groups were used and the degree of abstraction of their data was less (Hedin, Wolfe, & Arneson, 1977). However, these factors did not seem to limit the informants' abilities to discuss health with the investigator; they had many ideas to offer, and they *were* concerned about their health.

All of the informants presented *mental and physical health as major constituents of health*, but they had more difficulty explaining mental health and mental health strategies. This may be because mental health is more abstract and individuals in this age group do not have much experience thinking in highly abstract terms. Their frame of reference is childhood which does not provide a large repertoire of analyzed emotional experiences (Mitchell, personal communication, July 23, 1987). Only one of the informants from the athletic group used childhood examples when discussing mental health characteristics and strategies, the others referred to friends and family and current life examples. The inability to articulate specific strategies did not take away from the importance that the informants placed on developing inner strength and self respect. The adolescents in the Minnesota study (Hedin, Wolfe, & Arneson, 1977) described similar mental health strategies: "having a positive self-concept and good relationships with others," were means to health and their relative importance was similarly stressed. Unfortunately, the Colorado group (Magilvy, et al., 1987) did not address this issue.

With respect to health promotion, a consistent theme was that *mental health carries more weight and precedes physical health*, even though physical health was "more obvious." Physical health was seen to represent health superficially. In developing health, strategies for mental health were seen as the most powerful because "if you have mental health then physical health just naturally follows." This study appears to be the only one that obtained detailed data about adolescents' views on the process of being or becoming healthy. That mental health is a precursor to physical health was also presented by the informants in Morse's study (1987) of lay perceptions. In addition, they described the reverse relationship; however, these adolescents informants did not. There was complete agreement about the interaction of physical and mental aspects of health.

Another theme that related mental and physical health, which was not apparent in other studies, was that ***compromised physical health could be compensated for by mental or physical health strategies*** (with an emphasis on addressing one's attitude or outlook as a strategy). That is, health status need not be threatened by deviations from "normal" physical health. The reverse was *not* specified -- physical strategies could not compensate directly for mental health concerns. However, some informants acknowledged that a gradual improvement in physical health could be "helpful to one's mental well-being." The reason that "gradual" was used to modify improvement was because the informants believed that with poor mental health, great physical health improvements were less probable. This idea underlines the importance that the adolescents gave to mental health strategies and the power of individuals in promoting their own health.

Coping was also identified by all of the informants and it included mental activities and physical strategies. It is interesting that the informants could identify and classify some ways to cope, but there was some struggle with the concept. Despite the struggle, they emphasized that ***coping was an important strategy for health.***

The informants had a beginning understanding of the effect of stress and made it clear that they saw stress, coping and health as related. Of the 9449 fifteen-year-old students who participated in the *Canada Health Knowledge Survey* (1984), "just over one half knew that mental illness is most often caused by stress, but only one quarter knew that some degree of stress is healthy for the body" (p. 38). All of the nine informants in the present study thought that some stress was healthy for ***the whole person*** (mentally and physically). These informants likely represented a more aware group than the random selection in the survey. They said that one who coped well promoted health because one minimized stress and one demonstrated health because one had some control over one's life.

"***Control***" was another major theme. These adolescents perceived a high degree of control over their health and less dependence on health professionals than was reported in most other studies of adolescent or lay perceptions of health (Baumann, 1961; Di Cocco &

Apple, 1960; Hedin, Wolfe, & Arneson, 1977). It is possible that there was a noticable difference in these individuals' ideas about control because of the nature of the informants selected; or, it is also possible that the open-ended nature of the interviews and the fact that the researcher was not associated with a clinic nor emphasized her nursing role allowed the discussion about personal control to appear. Morse's study (1987) on lay person's perceptions of health also discovered a perspective of personal responsibility and she used interviewers who were not health professionals.

Orem (1971) wrote that "the activities of self-care are learned relative to the beliefs, habits, and practices that characterize the cultural way of life of the group to which the individual belongs" (p. 14). There was a suggestion that these young adults were willing to practice self care; in fact, they implied that they preferred it, and they had their personal ideas about the activities of self-care. *The informants said that having control over things in their lives made them "feel good" and promoted mental and physical health*; but they could not explain *how*, that is, the processes involved. They said that being calm and controlled facilitated coping and demonstrated an attribute of health. The importance of control and self direction were integral to the process of health promotion for these adolescents.

The final theme evident in these adolescent's ideas about health was called *Rusty's Triangle*. The "triangle" was actually a graph representing *a curvilinear relationship reflecting an optimal amount or degree of an attribute or strategy in relation to degree of health*. It is significant that these informants could conceptualize the relationship between attributes and strategies to health at this level of abstraction. The variables listed as applicable to Rusty's triangle were: exercising, eating, sleeping, stress, worry, and weight. These variables likely represent those which the informants understood best.

In summary, most of the themes identified in this study are consistent with the findings of other related research. Several themes were more thoroughly explained in this study, or were unique to the study, because of the "narrow" focus and the methods used. It is remarkable that the adolescent view shared many similarities with other studies about lay perceptions of health, inclusive of those with adults, seniors and other age ranges in adolescence, and that the major differences were in the emphases.

The Influences

Variables that were seen to influence health status and health perceptions were identified spontaneously by the informants but some open-ended, structural, and comparative questions were also incorporated to elicit these data. Athletic informants had more to say about influences than academic informants; they seemed more aware of the development of their perceptions of health.

Peer influence was evident in this study. However, peers were seen to influence only some health behaviors, and for these behaviors they had much influence (seen as positive and negative). Peers were seen by these informants to have little influence on their health perceptions because health as a concept was rarely discussed among them. They indicated that discussions with friends almost never were about health per se; the topics related to diet, exercise, and "whether or not you should smoke or do drugs." In addition, as mentioned earlier, the informants revealed that masking concern for health is a cultural norm in adolescence. However, it is clear from the findings that the attitudes and beliefs of friends were influential. But, as Bibby and Posterski (1985) noted, adolescents likely choose peers who have similar values to their own, thus the real influence may come from within, from the "self," as postulated by this group.

Next to one's "self," family was seen as the most important influence on health, especially related to *illness experiences* in the family context. Even though the family was seen as important to the development of health perceptions and to one's health status, the informants did not focus their discussion on this variable, perhaps because the influence was past-based. Another strong influence was the media, and this variable was described as a present influence. Life experiences related to illness, including illness in self and others, were also identified as important influences.

Studies about health attitudes and behavior often incorporate questions with pre-defined categories about where adolescents get health information (Bibby & Posterski, 1985; Green, 1979; Perry, Griffin, & Murray, 1985). By using open-ended questions with these informants to reveal who or what was seen to have influenced their health status and health perceptions, the stated influences were more internally valid. However, their degree of importance must be interpreted with caution because of the nature of this study and the small groups involved. In fact, the degree of importance of the identified influences varied and the above statements were the only clear, consistent points.

The informants did not indicate that professionals had much to do with their health status, and they only referred to a few health professionals or educators that had influenced their perceptions. Some of the informants openly criticized the perspective of doctors and health educators, because it differed from their own or because they used inappropriate methods, such as "scare tactics."

These adolescents were healthy and claimed to have little contact with health professionals. It may be that well adolescents are ignored as a target population in health promotion efforts and their usual contact with health professionals is when there are health crises. A broader cross-section of adolescents may have yielded a different response with respect to the influence of health professionals. The Minnesota group (1977) and Green (1979), through his "adolescent participation in health care project," identified different adolescent views of the impact of nurses and doctors on health. However, the studies were done for the purposes of health planning and this had been made clear to the adolescents, and therefore may have biased the adolescents' responses. This study focused on understanding the conceptualization of health and was not about health services.

Health education was hardly discussed, even with probing. Recall seemed to be poor, although the informants may have been afraid to state what they had learned for fear of judgement. Nevertheless, the impact of health education seemed to be minimal.

In addition to the inductive data about influences, variables that were identified in the literature as likely to influence health perceptions are discussed. The first of the seven variables, the presence of illness, as described earlier was seen as influential in terms of illness in others and personal experiences with illness. Personal experience with illness was seen as having a stronger effect. As stated earlier, illness is identified as a consistent influence of health perceptions in the literature (Morse, 1987; Payne, 1986; Tam, 1983; Tessler & Mechanic, 1978).

Another variable identified was "cultural." This study is focused on this variable in terms of the adolescent culture and subcultures within it but not in terms of ethnic variation. All of the informants were from white middle to upper class families and the cultural variation was minimal. No conclusions are identified about the influence of ethnicity nor socio-economic status.

Educational level was also identified in the literature. The informants' educational experiences were described as influential but each individual's memory of "health classes" was limited. Thus, what was learned in school was said to be relevant to health perceptions, but the degree of impact appears to be low and the details of areas of influence are "fuzzy."

Age as an influencing factor of health perceptions was a primary consideration in this study. Most of the informants spontaneously referred to variation in their thinking about health in previous ages and stages in their life. Thus, changes as one developed influenced one's health perceptions, according to these informants. How age affected health perceptions was considered by other researchers and has been confirmed by this study (Bibace & Walsh, 1980; Eiser, 1985; Elkind, 1984).

The evidence of gender differences were only present in terms of the differences related to a specific characteristic of health and were not evident in any other area. This was not unexpected for this age group.

One of the most important influences that the informants identified was the influence of their family, *especially their parents*, on their health perspectives. This is one of the variables discussed and studied in the health promotion literature, for example Duffy's study (1986) on single parent families' health teaching practices, or Mechanic's (1964) exploratory study of mothers and their children's health attitudes and behavior. Since the focus of this study was on the structure of the concept of health to adolescents and what influences it, the *process* of family influences was not explored. This does not mean to indicate that the influence of the family is not important.

The data about influences on health status and health perceptions were difficult to elicit; the informants usually had difficulty thinking of past influences except in relation to their family and illness experiences. It was not always clear from their comments how something influenced their health, nor the degree of influence, especially in comparing informants' ideas.

Comparison of the Results to Selected Models of Health

> "It is within nursing's domain to mediate between the biomedical (etic) model and the patient (emic) model; to understand, interpret, and intervene based on what both the [client and health professional] are perceiving" (Tripp-Reimer, 1984, p. 103).

It is important that the way that adolescents classify and structure the concept of health be understood in relation to theoretical frameworks of health, especially those used by health professionals. When health professionals consider and integrate the emic view of those whom they serve, the promotion of health is more likely to be achieved. In this section the emic view discovered from these adolescents is compared to selected deductive models and conceptual frameworks of health.

Evidence of Smith's (1981) four models of health, (*clinical, adaptive, role performance,* and *eudaimonistic*), were present in these informants' comments. Smith states that each model, starting from the eudaimonistic model, subsumes the models below it, and that the four models represent levels; these adolescents' views were consistent with this framework. They said that physical health was thought of as the absence of disease, but that this would be "the basic minimum for health."

Role performance and adaptive models were emphasized the most, and about equally. This emphasis is apparent in other related studies such as Payne's phenomenology (1986), and Magilvy's et al (1986) "ethnography" of adolescent health. The informants presented the role performance model in terms of health being a *means* for doing things in life. Their views that related to the adaptive perspective involved more complex and abstract interpretations of health; they involved processes and interrelated strategies.

The adolescents' comments that reflected the eudaimonistic model consisted of abstract terms; this model was seen as virtually unattainable, but as an appropriate and idealistic health goal. The eudaimonistic perspective was most apparent in the adolescents' discussions about their *experience* of health: "things just flow naturally" and "you have a feeling of general happiness." Again, Payne's (1986) study reflected similar expressions. All of the four models were evident in each of the informants' comments; that is, each individual could conceptualize health in the four levels described by Smith, but the emphasis was, as stated, with the middle levels.

One can conceptualize health promotion as generating, developing, maintaining, protectng and restoring one's health (Simmons, 1986). These adolescents emphasized means to develop (that is, "improve"), and maintain health. The ideas of protecting and restoring health were evident. The idea of the generation of health appeared to be beyond the adolescents' explicit abstract explanations, but in their discussions about the power of influence that one's inner strength and one's self-respect had, there were hints of understanding sources of, or the generation of health. It is not clear if the adolescents lacked a broad view of health or if this deductive framework of health is too broad to be conceptualized by lay persons.

The next theoretical comparison is with Antonovsky's (1979) *Salutogenic Model of Health*, primarily, with the *major psychosocial generalized resistance resources* (GRR's), and the core variable, *sense of coherence*. Antonovsky identified these ten GRR's: a) material,

b) knowledge, intelligence, c) ego identity, d) coping strategy, e) social support, f) commitment: continuance, cohesion, control, g) cultural stability, h) magic, i) religion, philosophy, art, and j) preventive health orientation (Antonovsky, 1979, p. 184). From these data, eight of the ten GRR's were identified, considering Antonovsky's definitions, as strategies. The GRR's that were not evident were "material" and "magic." Given that Antonovsky's model is a complex model and was based on an integration of much research and deduction, these adolescents' broad view of health strategies was impressive.

Antonovsky describes *sense of coherence* in his work. It is defined by him as:

> ...a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected (Antonovsky, 1979, p. 123).

These informants' emphases on having control and a positive outlook, as well as the idea that health is "all-encompassing" are consistent with Antonovsky's definition and perspective.

The final model chosen to contrast with these results is the *Health Belief Model* (Maiman & Becker, 1974). The ideas of *readiness* (perceived susceptibility), balancing efforts against outcomes, and the internal cueing that must occur to move one to take health action were evident in these informants comments about the strategies for promoting health. However, the variables that might influence these three conditions were hardly evident. The model that was gleaned from these data more closely approximates a process of promoting one's health because of the presence of an internal will to live rather than a reaction to feeling susceptible in an environment. The will motivates action for self-care as much as or more than the perceived susceptibility. The *Health Belief Model* has been criticized for its lack of an open systems process orientation (Rosenstock, 1974).

The implications of these results and their relationship to theories of health used by health professionals are great. Problems in effectively promoting health of adolescents could be the result of the differences in frameworks used by health professionals and the adolescents' emic view.

Discussion of the Research Methods

Understanding meaning within a culture is a challenging undertaking. The meaning of an abstract concept such as health is subjective and therefore variable within a culture or subculture. Consequently, using an inductive approach to understand an adolescent perspective of health was imperative. The inductive methods used in this study are discussed in the following order: an overview of the *Developmental Research Sequence Method* (d.r.s. method) developed by Spradley, (1979), the sampling method and the chosen sample, the interviews and questions, and finally the analyses.

The D.R.S. Method

The d.r.s. method was used to elicit subjective, perceptual information from selected informants. The open nature of this method provided a framework to approach the informants in this study with the least bias from the investigator. The d.r.s. method allowed the questions and analyses to be guided by the informants in order to produce a valid ethnography. For example, the informants almost completely overlooked safety and environmental issues' relationship to health. Because the informants were directing the content of the discussions, this finding became evident. In addition, the method was flexible enough that it allowed the investigator to ask these informants about their views on health in relation to safety, *without making assumptions about their answer*. Had a method that was not directed to the informants' words and understanding been adopted, the fact that these young people do not see safety and health as closely related may have been overlooked, or falsely understood.

Sample

Arranging for informants through trusted adults in their environment was very useful in that there was an instant trust; this was also facilitated by the nature of the consent forms which emphasized confidentiality and anonymity. The trust was evident when, at the end of the first interview and informant stated, "I had no idea what to expect, but I wanted to do this anyway....It was fun!"

Both of the subcultural groups selected for this study were appropriate for this study in that they were willing and able to engage in detailed discussions about health. Data from these informants varied little in a general sense; the data saturated with fewer informants than expected. Although the groups crossed-over, there was some evidence of subcultural group differences. It is possible that the informants selected for this study were about as close to being "academic" or "athletic" as *most* adolescents are to any subgroup. Male and female informants in this study had very similar ideas which is more typical of this age group than any other (Mitchell, 1986).

None of the informants had difficulty being audio tape-recorded and they seemed to enjoy the fact that what *they* said was important -- important enough to be recorded. The informants reported that they enjoyed using Cantril's Ladder to focus the discussion, and they found the card sorts "interesting." That is, they said that reading the cards and the sorting process made them think more about what they and other informants had said about health.

Participating in this study was seen by these informants as useful time to reflect on their own health beliefs and health status. One informant said that he had changed some of his habits to improve his health as a result of the discussions in the interviews. Other informants admitted to thinking little about their health inbetween interviews but that during the interviews they engaged in critiquing their own health beliefs and practices. Thinking little about health reflected the usual mindset that adolescents reported to have about health issues rather than a lack of interest in the study. Despite the fact that the informants said that they think little about health, the informants had much to say in the interviews about it.

Data Collection

Overall, the use of taped, private, face-to-face interviews was successful in efficiently obtaining adequate data. The informants felt free to "talk," some of them admitted to trying drugs or drinking, at the same time implying that they would not want their parents or others to know. There appeared to be no concern that the investigator was judging their opinions; when clarification was requested, the informants did not in any obvious way change their mind or "edit" their comments to suit the investigator.

The informants all noted that the details they shared were not likely what their friends would say to one another and *not* what they would be saying to their friends. Therefore, the use of private interviews for this age group to eliminate the potential for peer suppression was supported. However, the reverse may also be true; having private face-to-face interviews may have biased the responses to be aimed toward what was thought to be more acceptable for the investigator to hear. Given the amount of probing required to attain understanding, written responses to similar questions would have interfered with these important comments becoming explicit.

On few occasions the investigator thought that the "researcher effect" was present and that the informant was presenting ideas to please or lead the interviewer. Most of these suspicions were later validated by contradictions or explanations that came later in the interviews. For example, one time after the interview "ended," (the tape was turned off) an informant elaborated one some aspects of his personal life that supported a suspicion that he may have been leading the interviewer regarding some of his comments about coping. Instances such as these were recorded in the field notes and used in analyzing and interpreting the respective segments.

Sometimes some of the informants had their "own agenda" and just wanted to tell the investigator what they wanted to say and the questions had little use in focussing their comments on what they or the others had said, for exploration or clarificatiion. When this happened, to communicate acceptance and allow some control, the investigator allowed them to express their views and moved into more structured activities such as Cantril's ladder or the card sorts when a natural break occurred. Therefore, the opening questions were useful but only to a point. With all of the informants the use of the card sort technique and Cantril's

Ladder elicited good yields of quality and quantity data.

Final verification interviews were very helpful in validating the later findings from the analyses and for clarification. Showing the taxonomies to four of the primary informants was valuable; many categories became more distinct and assumptions were validated or refuted. However, the informants were polite in their responses and very agreeable and the investigator had to be *very direct* in obtaining critical feedback. The investigator had to repeat questions like the following several times: "Is that *really* what young adults would say?" or "Does that fit for you?" These questions gave the adolescents permission to be "negative" and disagree and allowed for some important feedback and clarification. Thus, verification interviews that were done face-to-face and on the telephone contributed significantly to the internal validity of these findings.

Using secondary informants was also valuable. They were interested and amazed at what the taxonomies revealed. In their amazement they supported the idea that health is a process and experience that is largely outside of conscious day to day experience in this age group. In their feedback, the secondary informants also indicated support for the structure of the taxonomies and the content of the "themes." In addition to asking for verification directly, to improve understanding the analyses provided a mechanism to reach maximum understanding of the informants' viewpoints collectively.

Data Analysis

The investigator depended on the assistance of an expert in qualitative data analysis, who was an experienced ethnographer and had completed a qualititative study on lay health perceptions, to examine the data and analysis. Some mistakes in the analyses were made and these and other significant aspects of the process of data analysis that occurred in this study are highlighted in the following paragraphs.

After three interviews, (with three separate informants), the transcripts were cut into segments and sorted; five domains emerged. These data were reviewed by the thesis supervisor, who suggested that the clippings were too short and therefore more easily misunderstood. The interviews were processed for sorting a second time and this resulted in three domains. After about six more interviews, the categories began to emerge within the domains, and two of these *categories* were the same as the two original "domains" identified. Thus, redoing this step early prevented the investigator from distinguishing a category as a domain, (which is actually taxonomic analysis), and therefore perhaps from doing further analysis too soon.

If sixteen adolescents had been interviewed two or three times, the investigator would have had about 1200 pages of transcripts. There were about 600 pages of typed interviews and there were times when the volume of data seemed overwhelming. Almost every page of transcript provided useful segments; in many cases the whole page was used.

The field notes and the diary were useful in interpreting some of the informants' comments, but the field notes were *more* useful in this regard. The diary was mainly useful to the investigator in that the management of the project was reviewed and reflected upon for consideration of relevant changes or means to pursue that would facilitate completing the study. For example, it was while writing in the diary that the investigator saw the problem that waiting longer than two weeks between interviews made "connecting" with the informant more difficult in second and third interviews. It almost went "unnoticed" *during* the interviews because the investigator was concentrating on the content rather than the process. Also, it was in the diary that the investigator expressed the experience of having "difficult" parts in the interviews, which later was identified as the incongruent confidence that the informants had in relation to their actual understanding.

Some of the details in the field notes did not seem important to the results of this study, such as the grooming and appearance of each informant. However, these details were useful in observing similarities and differences of the persons in the subgroups, in addition to the demographic data. By far the most useful comments in the field notes in terms of the findings of this study were the "memos." Sometimes a theme, for example: ***goals are a way*** *to health*, would appear in the field notes several times in different forms, discovered through different processes. The repetition was interpreted to mean the idea was probably grounded in the data.

A final part of the analyses that was helpful for interpretation, but did not necessarily validate the findings, was the opportunities for informal discussion of the "tentative" findings with nurses at a research conference, with community health nursing colleagues at work, and with other graduate students in nursing and related fields. Their impressions were helpful to the investigator because they assisted in clarifying significant points. Their comments about whether the "findings" fit their impressions of adolescents and their health gave the investigator ideas about the interpretations and in some cases, the interviews were refined, to explore new issues. An example is related to a question a colleague asked about the informants' ideas on pollution -- again this was noted to be absent and the next informant was asked about pollution and health.

During data collection, the comparison between the two subcultural groups was performed between interviews using the content in complete transcribed interviews and therefore the comparison was between informants rather than within the developing categories and subcategories. In later analyses, the interview *segments* from the groups were separated and placed into only the major categories for comparison. Theses errors resulted in fewer distinctions between the subgroups becoming evident. After consulting with an experienced qualitative researcher, the data were re-sorted into smaller categories and the subgroups were analyzed within the smallest subcategories.

In summary, the d.r.s. method of data collection and analysis, with support from an experienced ethnographer and others, provided useful structures for obtaining adequate and appropriate data to build this ethnography. The informants selected provided richer data than expected and nine, as opposed to sixteen informants, were required to participate. Although there were many positive aspects to discuss in deliberating about the methods used for this study, some limitations are noted below.

Limitations of the Study

Given that the research questions and the purpose of this study were to understand the way that adolescents conceptualize health, describe their emic view of health in written form, and to identify perceived influences on health status and health perceptions, the proper methods of sampling and data collection were utilized. The data were *adequate* in that they were complete and represent the concept of health, or its meaning, accurately (Morse, 1986). Sandelowski (1986) refers to the qualities of the data as being *credibility, fittingness, confirmability,* and *auditability*. The first three qualities are met as is described in the discussion of the methods and the findings. "Auditability is achieved when the researcher leaves a clear decision trail concerning the study from its beginning to its end" (Sandelowski, 1986 p. 34). By using Spradley's (1979) d.r.s. method, including field notes, a diary and memos, and by the presentation of this written report, the method used for this study is clearly outlined, and thus the study is auditable.

One limitation is that there were some areas, particularly in relation to process data and the influences, that the data were "thin." However, overall the data were sufficient in quality and quantity to write a valid partial ethnography.

The other possible limitation is that there was lag time that occurred between some interviews. The informants had difficulty remembering what they had said especially if more than about two weeks had elapsed. When there was a long break, the investigator reoriented the informant with a summary of what he or she had said. The summary may have included some of the integration of ideas, or analysis, and thus may have influenced their subsequent responses. However, this process sometimes improved the quality of the data because the informants would respond to the investigator's comments with clarifying statements, or responses like "Oh, yeah! I also wanted to say this:...." In summary, by the factors already stated, and by having verification interviews, using secondary informants, *and* reviewing the data at times during data collection and analysis with and expert in the methods and content of this study, the structure and themes of the concept presented in the results are assumed to be "grounded" in the data. That is, the results reflected what these informants said in their discussions about health.

In summary, an adolescent perspective of health was developed through the process of ethnographic interviewing and the d.r.s. method. It included a description of health, including the characteristics of health, and strategies for promoting health. The adolescents conceived health broadly; the method for this study probably facilitated a broader view of health than has ever been elicited from this age group. The findings of this study "fit" with other inductive studies. Therefore, these results are valid and probably represent the subcultural groups of adolescents sampled. Nevertheless, it is not known to what degree the data apply to adolescents; the data cannot be interpreted to represent the frequency of the beliefs and themes in the population. Furthermore these data are representative of these adolescents' perceptions as a whole, rather than any one individual's perspective.

Implications for Nursing

When one considers that these adolescents were able and willing to spend three hours discussing health then one may assume that these people care about their health and have been accumulating important information for caring for themselves. This study justifies some optimism for health professionals who are assisting adolescents to promote their health. Firstly, these informants appear to take responsibility for their health, and they can describe effective strategies for doing so. Secondly, health is conceived broadly and there was a genuine interest in understanding the concept. The following comments are the implications for nursing practice given the findings of this study. In addition, the implications for adolescent health education are specifically addressed and it is assumed by this writer that nurses will have this responsibility, although the implications for education are applicable to whomever is charged with this responsibility.

There is evidence in this study that these adolescents have learned much about health. However, the learning has occurred in many varied settings, and not, according to these adolescents, necessarily in the traditional learning settings. The family were reported to have the strongest impact on these adolescents' views. This suggests that health professionals might consider health promotion activities for *families* with school age children (as a group), and evaluating the impact of such activities.

The adolescent age group is receptive to health education through the media. Nurses need to consider working with experts in various media to capitalize on the environment that these young people *live* in. It is possible to incorporate current videos, movies, songs, sports heros, and "stars" in written material, audiovisual programs, lectures and presentations to make the material interesting and relevant. Mundane pamphlets on AIDS or smoking that merely present the facts, sometimes not believed by these informants, are not powerful influences, but they could be.

In addition to the family and the media, another influence seen as important was one's *internal perspective*. Therefore, strategies to affect one's internal perspective could be presented. These adolescents conceptualized health as mental and physical; they *emphasized* the mental, yet they were unable to be explicit about the strategies. Thus, health teaching need not be limited to "the basics," (exercising, eating, and sleeping). Mental health promotion can take many forms, and since the strategies were unclear to these informants, perhaps an emphasis needs to be placed on mental health strategies. Often a school nurse is approached with social and emotional concerns of adolescents and nurses should consider that the young person may see these concerns as health-related, even though nurses may not believe this themselves.

Although these informants could discuss the concept of health, including strategies for health, their viewpoint differs from professional perspectives. Safety and environmental issues, and preventing acute and chronic diseases are not seen as *health*-related by these informants. The current emphasis on preventing disease and disability, combined with the adolescents' apparent "lack" of a strong preventative orientation and the fact that many risks are not evident to lay persons, including adolescents, may be responsible for the apparently poor impact of health professionals and educators. More likely, however, it is the differences in approach which are responsible. Although these data must be interpreted with caution, it would be worthwhile for nurses to consider that young adults may not make the same connection between health and safety and prevention as health professionals might. Perhaps different approaches to safety, environmental and other preventative issues are warranted. The dangers of pollution or the risk of a motor vehicle accident might be presented in the context of the quality of life in the future, rather than the disease or disability that may ensue.

These are examples of considering the subculture when planning strategies for health promotion. The end may be the same, but the means can and *must* vary with the population (see Tripp-Reimer, 1984 and Thorne, et al., 1986). The language used by nurses should be aimed at the words the adolescents use, such as "looking great" and "fit" as opposed to "good posture" and "body tone." For this subculture, it may be that nurses need to ***begin with the health priorities that adolescents have***, rather than imposing our goals based on disease incidence and statistics. Priorities may need to be more flexible so both groups can gain from the health encounter. For example, these adolescents emphasized mental health strategies, including coping and goaltending, and appearance as relevant aspects of their day to day experience. If this represented what many or most adolescents say, or if it represented what a group of adolescents in a school or program identify, then it would be wise for the health professional to start with these aspects, rather than start with something unrelated, such as teaching breast-self examination or eating fibre to prevent bowel cancer.

Health professionals have not considered young adults' point of view and many assumptions have been made in health programming. Unfortunately, the assumptions are invalid; that is, they are not based on an assessment of the knowledge, and more often, the beliefs and attitudes of the target population. These informants confirmed this as their experience in the health teaching which they were able to remember.

In working with adolescents, nurses must consider and account for the subcultural traits that were evident in this study. The first is that the confidence about health knowledge implied by these informants may not be indicative of a true understanding, but of a lack of information screened by a need to feel good and "have it together." Nurses must listen carefully to adolescents questions and concerns, and objectively assess the knowledge base whenever possible in planning health interventions or health education. The second trait is that adolescents present a front of resilence -- of being able to handle anything -- yet they emphasized the need to achieve and experience success. Thus, a successful health promotion activity likely would be one that has accounted for this and plans for the participants' success early in any program. Thirdly, it is probably essential to approach the adolescent with a context that the adolescent has an equal amount of, (or perhaps more), power in the relationship with the health professional (McNight, 1985). That is, the adolescent must be given the control of managing health, along with the responsibility for health. This final point is consistent with these adolescents' beliefs because they emphasized the influence of one's internal state on health. Without the power of the adolescent to take action, few health promotion goals will be met. Control, combined with privacy and independence, must be provided in the relationship.

In conclusion, the assertion is made again that any health promotion strategy *must* begin with an understanding of the cultural mileau. The services of health professionals are sometimes based on narrowly defined "health" goals or culturally different perspectives from the client (Spector, 1979; Thorne, Griffin, & Adlersberg, 1986; Tripp-Reimer, 1984). In these cases program effectiveness is minimized and valuable health dollars and professional efforts are wasted. The adolescents in this study and the data from other studies have indicated some difference in emphasis for the characteristics of and the strategies for health and these differences, if validated further, are relevant in health planning. Since nurses are actively involved with this age group in a variety of settings, nurses need to identify their own assumpitons and develop ways to gain the emic view of the target group before beginning a health encounter.

Recommendations for Further Research

> Too often, generalized impressions are made on the basis of need and interests expressed by a few articulate youths. These concerns are assumed to be applicable to the majority of adolescents, many of whom are less communicative (Levenson, Morrow, Johnson, & Pfefferbaum, 1983, p. 26).

The quote above reflects the major reason that further study should be performed to understand the adolescent perspective from an application standpoint. However, the quote also reflects the main criticism of studies such as this one. The defense of the methods for this study, including using "a few articulate youths," were stated earlier. These informants were articulate and some of them obviously had their own agenda. However, beginning to access an adolescent point of view with these individuals was appropriate given the lack of valid information about how adolescents conceptualize health, and as ~~more studies~~ such as Magilvy's, et al (1987) are completed and areas of agreement appear, the theory will become more valid and generalizable. The degree to which adolescent subcultural groups agree with the theory will merit further study, including quantitative approaches with larger samples.

The first recommendation as a result of this study is that further qualitative discovery with one or both of these subcultural groups *and* some of the other groups be performed to facilitate identifying potential differences. The replication would assist in validating these data, and subsequently studies for obtaining quantitative comparisons can be made within and between subcultural groups based on internally valid information. Information about how the adolescent comes to know about and promote health for him or herself would be invaluable information as a conceptual framework in health promotion intervention evaluations.

From inductively derived data such as these, some understanding of the degree of importance adolescents place on health characteristics, as well as the degree of impact that the adolescents perceive the strategies to have, could be assessed. Currently the studies evaluating health attitudes and education choose categories for data collection deductively. These studies have some use but likely overlook important areas for consideration, such as self-respect. The *Canada Health Knowledge Survey* (1984) had one mental health question in their collection tool. Data in this study probably only provide some direction on the aspects that are important but more thorough and valid information is required.

Obtaining information about the degree of influence that factors in the environment are perceived to have would also be valuable for health planning. The perceived impact of the family should take special significance because of the amount of time individuals spend with their family as children and because of the emphasis it was given by the informants in this study.

Corallary to the influences are the different *resources* for health that adolescents would identify. Given that they had many levlels of conceptualization of health, and each formulation has different implications and resources, these data should be obtained also.

Finally, because the issue of control and the power of one's outlook were evident as major themes and little is known about these in relation to one's health or the development of health, more qualitative data could be gathered focusing on these processes. These data could then be used to begin to develop research tools to assess each strategy and the factors associated with their development. The goal of the ensuing research would be to discover powerful ways of promoting health in the adolescent population.

Questions, that could be developed into hypotheses, are identified. Do adolescent subcultural groups have more differences than similarities in their conceptualization of health? What is the range of views about and the emphases surrounding the concept of health in the adolescent population? How do adolescent and health professionals' view of health differ, and what impact does this difference have? What degree of importance do adolescents place on aspects of and strategies for health, as well as that which influences their health? What health resources are optimal for different conceptual levels of health? How is the process of *goaltending* related to health promotion in adolescents? And, how does this vary between subcultural groups in adolescence, and compare with other age groups?

Obtaining more qualitative and quantitative data related to these questions will enable nurses and other health professionals to serve the adolescent population in promoting their health. Since adolescents often have been overlooked as a target group in health promotion and program priorities, new programs for health promotion can be planned to be based on assumptions arising from valid, grounded data about this unique group of human beings.

Summary of the Study

Using the technique of ethnographic interviewing an emic view of adolescent health was derived from nine key informants. The analyses of interview data, field notes and the diary entries were used to guide subsequent interviews. The first level of analysis was *domain analysis* which was designed to reveal the categories of health, which then comprised the categories that were used to structure the subsequent interviews and analyses. *Taxonomic analysis* involved examining the data to identify the structure of the concepts within the categories or domains. *Componential analysis* was used to identify which contrasts, similarities, and relationships between domains and categories existed. The two adolescent subgroups provided data from which contrasts and comparisions were made. Finally, *cultural theme analysis*, a higher level of analysis, was used to identify the principles that structured the understanding of a concept within the adolescent subculture.

The athletically-oriented and academically-oriented subcultural groups saw health as having mental and physical constituents that were interrelated. The academic informants focused the discussion more on the mental aspects of health and the athletic informants focused on the physical, although *both* groups began by discussing physical health. Although physical health attributes were important to these adolescents, mental health was *more* important. However, mental health was seen as more difficult to describe and attain. Health was described as being mostly out of awareness, unless one became ill. Adolescents rarely think about or discuss health; the related peer discussions centre around diet, weight, exercise, and what one should avoid (i.e. drugs, smoking).

Two taxonomies, one of health characteristics and one of health strategies, were developed. These reflect the organization of two aspects of the concept of health to the adolescents. In the characteristics they emphasized the physical; in the strategies, the mental category was the most important constituent.

Several major themes were identified. The two most significant to these adolescents were that mental health is more important than physical health, it was seen to precede it, and that goaltending is important to health. They saw that one's will to live, for certain reasons, motivated one to take care of oneself. This enabled one to goaltend, and thus gave one reasons to live. Being in control and the importance of one's inner perspective were emphasized in these young adults' beliefs.

The findings in this study are consistent with other qualitative studies of lay perceptions of health. The emphases in the data among this age group are apparently different than those for adults and senior adults; however, there are few studies for comparison. Of the studies of the adolescent age group, these findings are generally consistent with their results.

The rich descriptive data provided by the adolescent informants was used to build a valid representation of a group of adolescents' perspective of health. Although the focus of this study is on how adolescents structure the idea of health, there was much information that related to the process of health promotion. These adolescents conceptualized health broadly and generally have a eudaimonistic view of health. These findings are relevant to all professionals working to promote health in the adolescent population.

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APPENDICES

APPENDIX A

Description of Spradley's Four Kinds of Analyses:

Domain analysis. This early analysis simply identifies categories or themes that are evident in the data. Spradley calls this analysis a "search" (Spradley, 1979, p. 94).

Taxonomic analysis. This analysis is for the purpose of identifying the organizing structure of the domains found in the domain analysis. The result is a taxonomy of the domains of the concept in question. This step is a process similar to ethnoscience (Field & Morse, 1985).

Componential analysis. The result of this analysis is a structuring of the domains or categories of the first analysis with their descriptions to identify the differences (contrasts) (Spradley, 1979).

Theme analysis. "Theme analysis involves a search for the relationship among domains and how they are linked to the culture as a whole" (Spradley, 1979, p. 94) The emphasis is on using the domains that are derived from the data in the previous analyses. This analysis links the domains together in larger themes and is the basis for the description of meaning in the ethnography. Relationships among the domains and themes are are hypothesized and are supported, refuted, or are inconclusive.

APPENDIX B

Parental Consent Form

Project title: **Adolescent Health: An Emic Perspective**

Date:____________________

Investigator:
Lorraine A. Telford R.N. B. Sc. N.
Graduate Student, Faculty of Nursing
3rd Floor, Clinical Sciences Building
University of Alberta, Edmonton
T6G 2G3 Ph: 459-7043 (home) 459-6671 (work)

Student's Supervisor: Dr. J. M. Morse R.N., Ph. D. Office phone: 432-6250.

Purpose of the study: The purpose of this study is to understand the perceptions and meaning of health from the adolescent perspective. This information will be useful for planning further studies that deal with adolescent health, for example, studies about health education. (Please see information sheet that is attatched for further description.)

INFORMED PARENTAL CONSENT:
This is to certify that I, __________________________________, ______________'s guardian agree to his/her participation in the research project investigating adolescent perspectives of health.

I understand that I have given permission for L. Telford to interview him/her in my home or another private, quiet place that they mutually agree upon. I understand that there will be one to three interviews between 45 and 90 minutes long, about one or two weeks apart.

I have given permission for L. Telford to audio tape-record the interviews. I am aware that the interviews will be typewritten by L. Telford, and that identifying information will be removed from the tapes and transcripts. I have been told that the single copy of the interview code name matched to my child's name will be kept under lock, to maintain confidentiality and anonymity of my child and our family. I understand that at the completion of the study, L. Telford will erase the audio tapes, but will keep the anonymous transcripts for educational or research purposes only. I have given permission for L. Telford to use quotes from the interviews in her study and in publications and presentations following, providing my family's identity is not attached to the quotes. I have been informed and understand that the conversations in the interviews are confidential and the content will be used anonymously only.

Finally, I am aware that I may withdraw my child from the study at anytime without any pressure or penalty. I have been given ample opportunity to ask any questions about the study and have been given answers to my satisfaction.

Signature of guardian:________________________________

Signature of investigator: (L. Telford)________________________

APPENDIX B

Consent Form

Project title: **Adolescent Health: An Emic Perspective**

Date:__________________

Investigator:

Lorraine A. Telford R.N. B. Sc. N.
Graduate Student, Faculty of Nursing
3rd Floor, Clinical Sciences Building
University of Alberta, Edmonton
T6G 2G3 Ph: 459-7043 (home) 459-6671 (work)

Student's Supervisor: Dr. J. M. Morse R.N., Ph. D. Office phone: 432-6250.

Purpose of the study: The purpose of this study is to understand the perceptions and meaning of health from the adolescent perspective. This information will be useful for planning further studies that deal with adolescent health, for example, studies about health education. (Please see information sheet that is attatched for further description.)

INFORMED CONSENT:
This is to certify that I, ________________________________, agree to participate in the research project about adolescent health.

I understand that I have given permission for L. Telford to interview me in my home or another private, quiet place that we both agree upon. I understand that there will be one to three interviews between 45 and 90 minutes long, about one or two weeks apart.

I have given permission for L. Telford to audio tape-record the interviews. I am aware that the interviews will be typed up by L. Telford, and that information that would identify me and my family will be removed from the tapes and the typed copies that she makes. I have been told that the single copy of my code name matched to my real name will be kept under lock, to keep my identity secret. I understand that the tape-recordings will be erased by L. Telford at the completion of the study and that the typed interviews will be kept by L. Telford for educational or research purposes only. I have given permission for L. Telford to use quotes from the interviews in her study and other papers or presentations, providing my identity is not attatched to the quotes. I have been informed and understand that the conversations in the interviews are *confidential*.

Finally, I am aware that I may stop being in the study at anytime without any pressure or penalty. I have been given ample chances to ask any questions about the study and have been given answers to my satisfaction.

Signature of informant:______________________________

Signature of investigator: (L. Telford)________________________

APPENDIX B

BACKGROUND INFORMATION

Date ____________

Code name of informant ________________________(may be chosen by the adolescent)

Age of informant ____________ Sex of informant ____________

School grade of the informant ____________

Ethnic background ________________________

Father's usual occupation ________________________

Mother's usual occupation ________________________

Has anyone in your family ever been seriously ill? If so, please explain about the illness or illnesses in in this space.

APPENDIX B

The following passage is an example of the words that were used by the investigator upon first contact with a potential informant, in order to explain the study and what the informant could can expect from being in the study.

Information about the adolescent health study:

In this study you will be asked to explain your ideas of what health is, and to describe different aspects of health. I want to know about *your* perspective, so you are the "expert" on the topic. I will interview you at least once, and maybe up to three times, for about one hour each time. You will find that I will be asking alot of questions, and that I may want you to explain things in as much detail as you can. I am really interested in how you describe things that relate to your health. With your permission, I will tape record the conversations so that I can carefully describe what you and the other sixteen and seventeen year olds that I interview say about health. After talking to several people your age and making sure I understand what you and they say, I will be writing a "thesis" which will be a thorough description of the meaning of health to people who are your age. Hopefully, this will help people who are planning programs to help young adults with health problems, or, it could help those who work in the schools and other places to promote healthy lifestyles in young adults.

By participating in this study, you can help me understand how adolescents *really* think about health. Your explanations will be used in the study, without anyone knowing who you are (except me, and I will keep that *confidential*). After I am sure that you understand these explanations, you and your parent or guardian will be asked to sign a consent form. Even if you sign the form, you can change your mind about being in the study. After signing the consent form, one page of written information will be filled out, without your name on it, as background information. Then the interviews begin, and they can be planned for anytime or anyplace that is convenient to you, as long as it is private and quiet enough to tape record. If you have any questions about the study or being in the study, I will be glad to answer them anytime, even during the study.

APPENDIX C

QUESTIONS (Based on methods of interviewing described by Spradley (1979))

Introductory "questions:"
Explain to me a typical day that you might have, say for example yesterday. Describe all the experiences that you had, right from the beginning to the end. OR
Remember when you first learned about the idea of health. Tell me as much as you can about what this was like. Where did you first find out, who told you - answer questions like that.

Questions for directing the informant (if necessary):
How would you rate your health? (the informant can choose a description or a scale)
What does health mean to you?
How does somebody know that they are healthy?
Tell me about what you remember about health from as long ago as you can. Do you see health differently now, explain how if so?
What does one do to become or stay well?
What does good health mean to you?
How would you define health?
How does it feel to be healthy?
What do you remember about times that you felt very healthy?
What do you remember about times that you felt not very healthy (or ill)?
What were the differences in these times?
Tell me how you might know that someone else is healthy or not.
Tell me if, and how important your health is to you.
What do others your age think? (about any of the above)
Some young adults in a survey say that they worry about their health - is this so in your opinion?
Do people your age spend time thinking about being or getting healthy?

Note: The investigator intends to use the informant's words as replacements for ideas in the questions, to facilitate "shared meaning" (Glaser & Strauss, 1967).

Some questions are similar for two reasons: to check responses for internal consistency and variability (Dean & Whyte, 1958), and at the same time to encourage new content of the same area. Questions will be repeated over the interviews (Spradley, 1979).